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January, 1960
Vol. XLVI - No. 7

THE Journal OF THE FLORIDA MEDICAL ASSOCIATION

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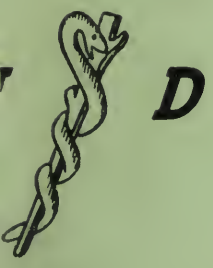

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bibliography: (1) Green, J. R., & Steelman, H. F.: Epileptic Seizures, Baltimore, Williams & Wilkins Company, 1956, p. 136. (2) Bray, P. F.: *Pediatrics* **23**:151, 1959. (3) Davidson, D. T. Jr., in Cann, H. F.: Current Therapy 1959, Philadelphia, W. B. Saunders Company, 1959, p. 512 (4) Smith, B., & Forster, F. M.: *Neurology* **4**:137, 1954. (5) Zimmerman, F. T.: *New York J Med.* **55**:2338, 1955. (6) Lemere, F.: *Northwest Med.* **53**:482, 1954. (7) Perlstein, M. A.: *Pediat Clin. North America:* **4**:1079 (Nov.) 1957. (8) Livingston, S., & Pauli, L.: *Pediatrics* **19**:614 1957. (9) Carter, C. H., & Maley, M. C.: *Neurology* **7**:483, 1957. (10) Keith, H. M., & Rushton J. G.: *Proc. Staff Meet. Mayo Clin.* **33**:105, 1958.

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VOLUME XLVI, No. 7

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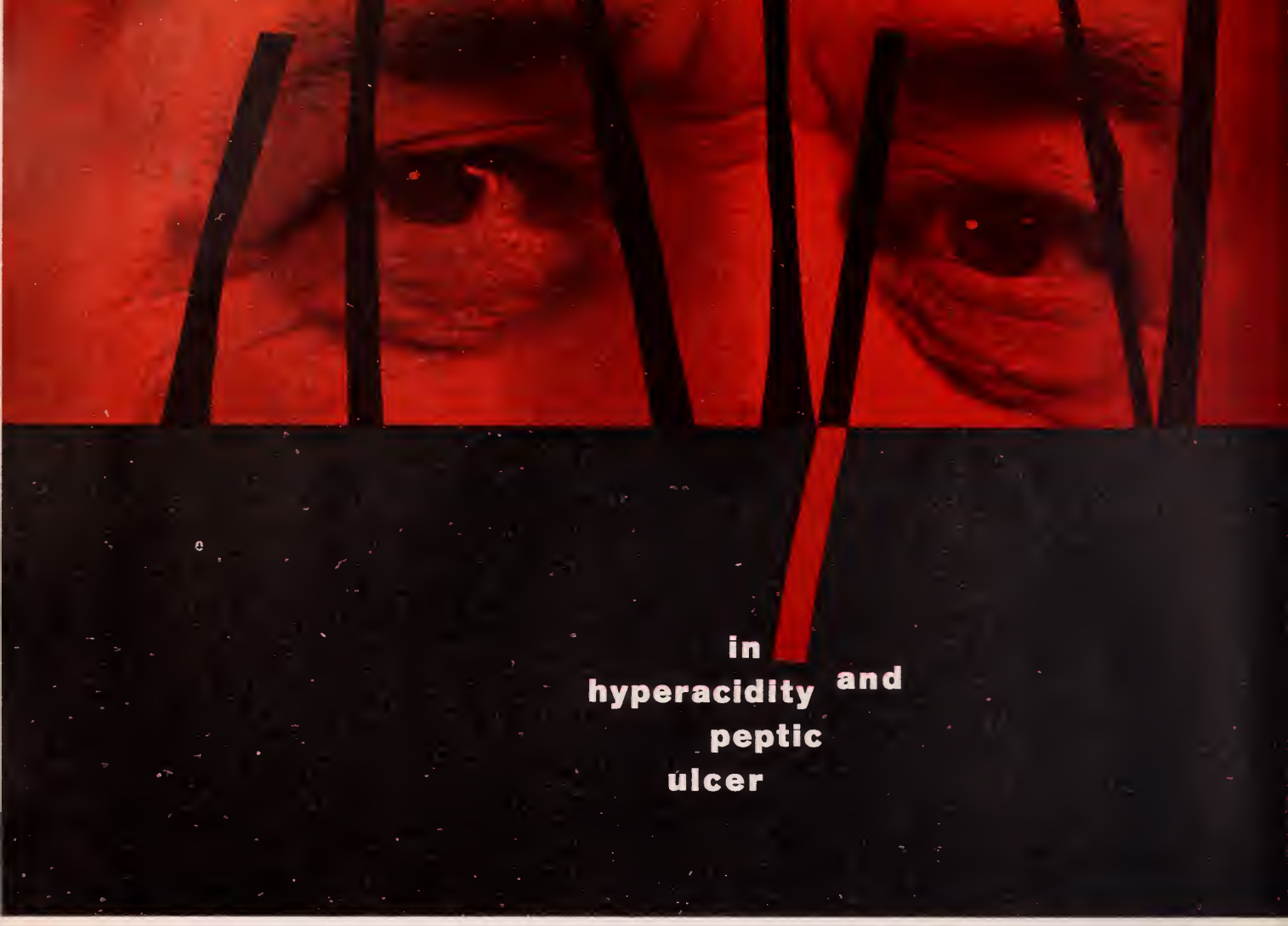
This Journal is not responsible for the opinions and statements of its contributors.
Owned and published by Florida Medical Association.

Published monthly at Jacksonville, Florida. Price $5.00 a year: single numbers, 50 cents. Address Journal of Florida Medical Association, P.O. Box 2411, 735 Riverside Ave., Jacksonville 3, Fla. Telephone EL 6-1571. Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918. Entered as second-class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida, October 23, 1924.



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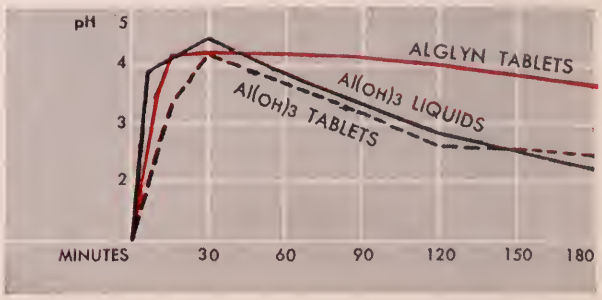

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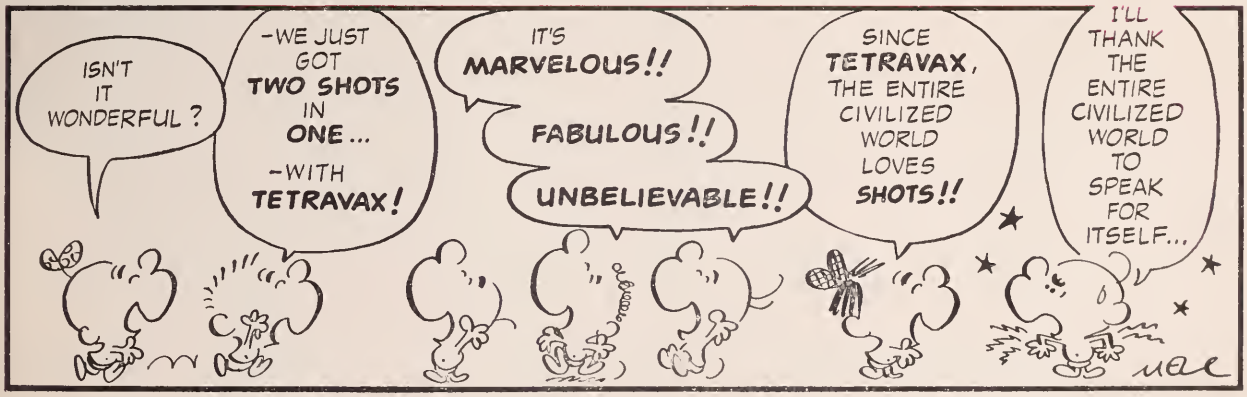

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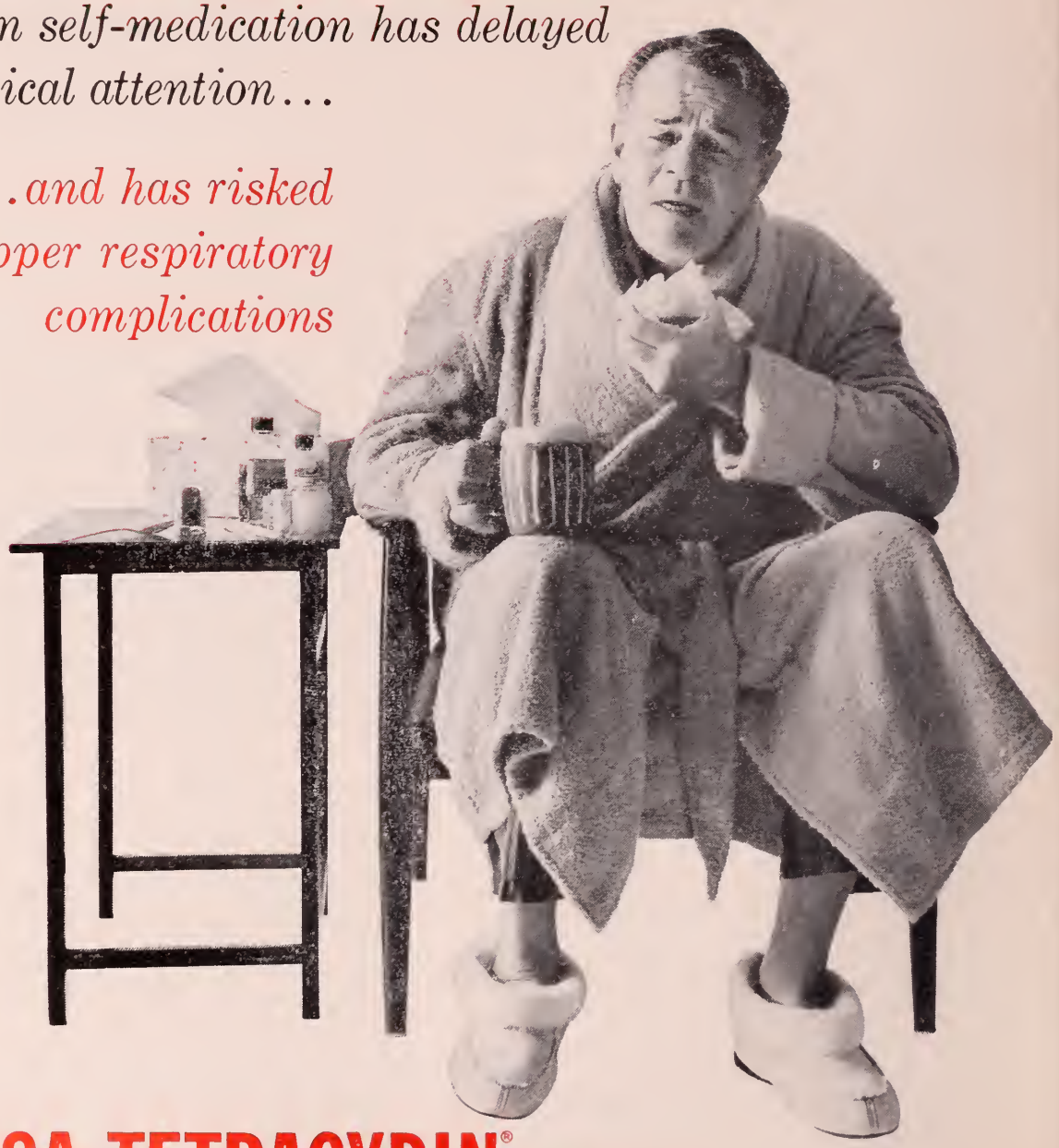

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1. Lippmann, O.: Arch. Ophth. **57**:339, March 1957
2. Gordon, D.M.: Am. J. Ophth. **46**:740, November 1958.

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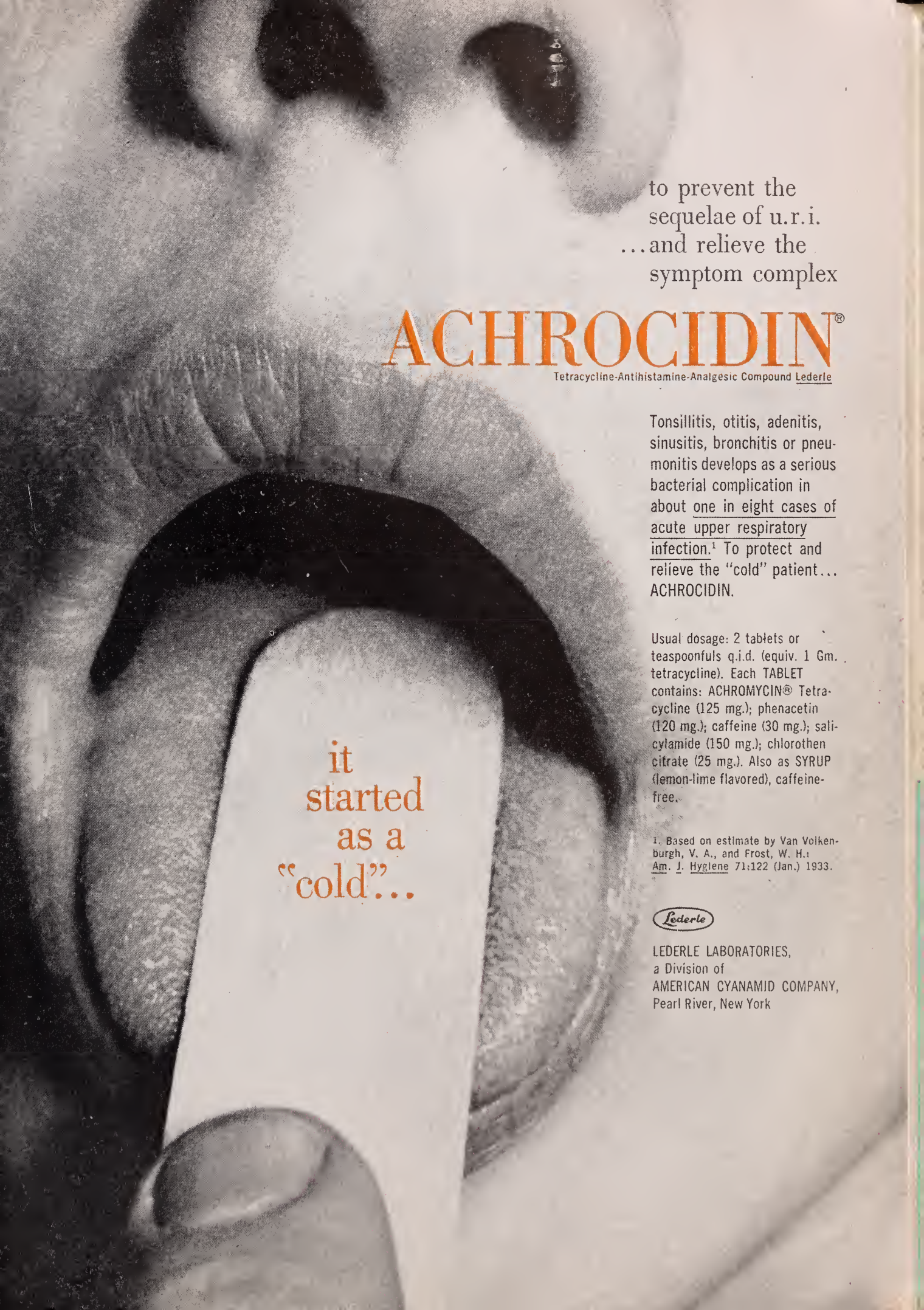

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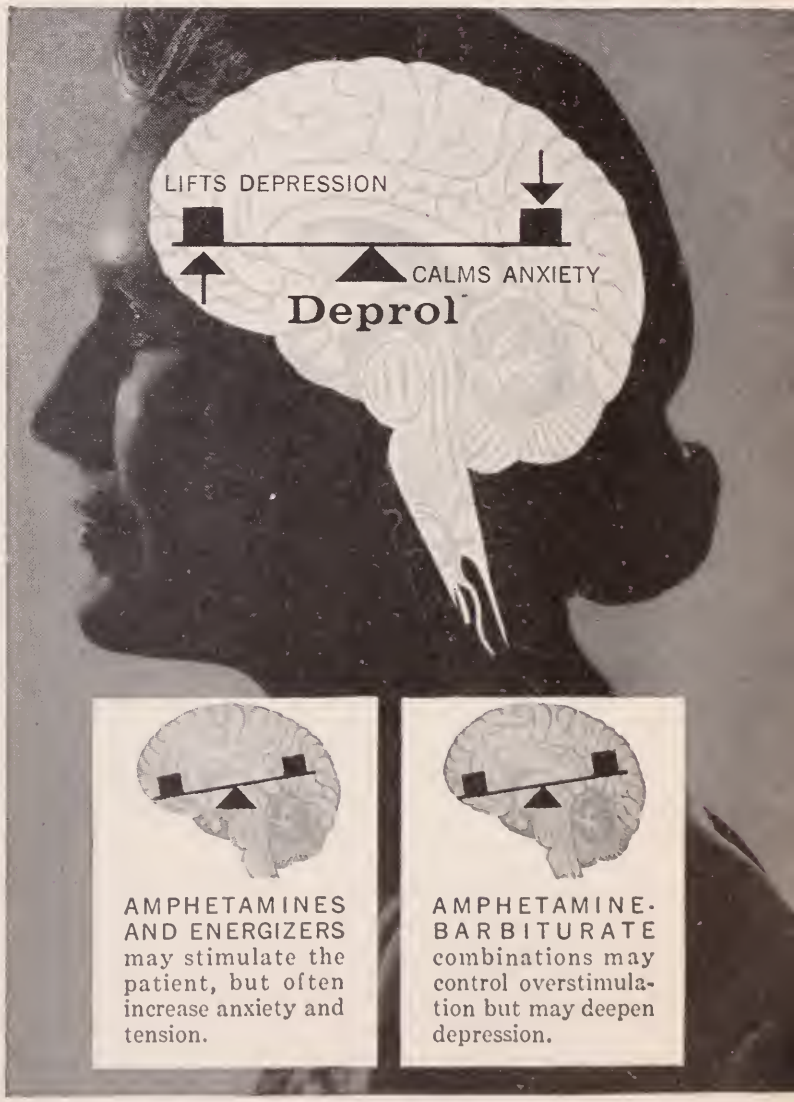

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THE JOURNAL
OF THE
FLORIDA MEDICAL ASSOCIATION

Volume XLVI, No. 7, January, 1960

Use of Gold in the Treatment of Rheumatoid Arthritis

L. MAXWELL LOCKIE, M.D.
BUFFALO, N. Y.

This evaluation was stimulated by the current trend of the increasing use of gold salts as a part of the complete program of management for the patient who has rheumatoid arthritis. Inasmuch as gold has been used in our clinic since 1933 it was decided to determine, if possible, what additional benefit gold salts were to the patient. A useful aid in this study has been the development of code sheets and I.B.M. Punch Cards to correlate the data.

It was found, after considerable research, that gold has been used medicinally since 2500 B.C. when the Chinese applied it externally. The first use of gold orally comes from the Bible in the chapter of Exodus where Moses triturated gold from the golden calf, strewed it over the waters, and made the children of Israel drink it to demonstrate that there was no physical effect. In 1500 Paracelsus believed gold to be the universal panacea. Of great interest is the report in 1825 when Hahnemann observed its use in the treatment of arthritis. Wood in 1893 treated a group of his patients who had rheumatoid arthritis using gold salts. Then in 1929 Jacques Forestier published a report on his large series of gold-treated arthritis patients in which he showed its beneficial effect. Since then it has been used universally with varying enthusiasm.

Since October 1932, in our clinic 3,120 patients with rheumatoid arthritis have been examined and followed for varying periods of time. In the early years not all patients were given gold salts as the use was delayed until a suitable period of conservative therapy had been carried out. This was especially true of the mild case. Since 1940, however, it has been given to all patients with reversible rheumatoid arthritis who were free of other serious organic disease. The gold salt was given intramuscularly at weekly intervals, and the duration varied from one injection to continuous administration over a 20 year period. The total amount ranged from 10 mg. to 12,230 mg. of gold salt.

Pharmacologically it has been found that during the course of weekly intramuscular injections, usually there is 0.4 to 0.8 mg. of gold per 100 cc. in the blood plasma. Approximately 1 mg. is excreted daily, with a weekly range of 7 to 10 mg. The synovial fluid does not show an increase in concentration.

In this study, on all patients a detailed history was recorded, a thorough physical examination made, and pertinent laboratory data and roentgenograms obtained, if necessary, for complete study. The individual program was explained in detail to each patient. The average time spent with the patient at this initial work-up was one hour and 45 minutes.

The broad program of management of these patients with rheumatoid arthritis consisted of a *minimum of three weeks strict bed rest* in the hospital at the beginning of the course of treatment. During this time physical therapy, including non-weight-bearing exercises, psychotherapy, analgesics, sedation, orthopedic aids and steroid therapy, when indicated, were used along with gold salts by intramuscular injection. This group comprised the "gold-treated" patients. The "control" group followed the same program

Read before the Florida Medical Association, Eighty-Fifth Annual Meeting, Bal Harbour, Miami Beach, May 4, 1959.

RHEUMATOID ARTHRITIS

Mark specified number in columns 6,7,8,9 and 68

Sex	Year of Last Visit	Age at Onset	Diagnosis	(6) Family History
1. Male 2. Female		1. 1-12 2. 13-19 3. 20-29 4. 30-39 5. 40-49 6. 50-59 7. 60-69 8. 70-79 9. 80	1. Gout 2. Rheumatoid Spondylitis 3. Rheumatoid Arthritis	_____ 1. Rheumatoid Arthritis _____ 2. Rheumatoid Spondylitis _____ 3. Gout _____ 4. Rheumatic Fever _____ 5. Other Collagen Diseases
1	2 3	4	5	

(7) Possible Precipitating Factors on Initial or Recurring Attacks	(8) First Symptoms	(9) First Area Involved	Status at First Visit
_____ 1. Respiratory Infection _____ 2. Emotional Upset _____ 3. Trauma _____ 4. Pregnancy _____ 5. Surgery _____ 6.	_____ 1. Pain in Joints _____ 2. Swelling _____ 3. Stiffness _____ 4. Fatigue _____ 5. Fever _____ 6. Loss of Weight _____ 7.	_____ 1. Hand _____ 2. Wrist _____ 3. Elbow _____ 4. Shoulder _____ 5. Foot _____ 6. Ankle _____ 7. Knee _____ 8. Hip _____ 9. Spine	A.R.A. Class: 1. I, 2. II, 3. III, 4. IV Stage: 1. I, 2. II, 3. III, 4. IV Activity: 1. None, 2. Mild, 3. Moderate, 4. Severe 10 11 12

Mark 1 for a Yes answer in numbers 13 thru 67 unless there is a choice of numbers

Associated Physical Findings	Special Studies-First Exam	Special Studies-During Therapy
13 _____ Nodules 14 _____ Cardiovascular Disease 1. Cardiac 2. Vascular 15 _____ Hepatomegaly and/or Splenomegaly 16 _____ Others 1. Iritis 2. Urethritis 3. Raynaud's 4. Renal Stone 5. Psoriasis 17 _____	18 _____ Sed. Rate 1. Normal 2. Increased 19 _____ Anemia HB < 80% or 11.5 grams RBC < 4,000,000 Hematocrit < 40 20 _____ WBC 1. under 5,000 2. between 5,000 & 10,000 3. over 10,000 21 _____ Urinalysis 1. Normal 2. Abnormal 22 _____ Uric Acid 1. Normal 2. Increased 23 _____ Miscellaneous	24 _____ Sed. Rate 1. Normal 2. Increased 25 _____ Anemia HB < 80% or 11.5 grams RBC < 4,000,000 Hematocrit < 40 26 _____ WBC-under 5,000 27 _____ Urinalysis 1. Normal 2. Abnormal 28 _____ Uric Acid 1. Normal 2. Increased 29 _____ L. E. Cells 30 _____ Photograph 31 _____ Special Tests

Figure 1.

except they received small doses of a hemolytic streptococcus vaccine in place of gold salts.

Only patients who had been observed weekly, by the physician, for a minimum of three months were included in this study.

Gold sodium thiomalate (Myochrysine) was used generally, but a small group was treated with aurothioglucose (Solganal). It was given intramuscularly at weekly intervals beginning with 10 mg., then 20 mg., increasing to 40 mg. weekly for the major part of the gold salt therapy. A 24 gauge ¾ inch needle was used and the material injected into the deltoid muscle. This is more convenient than the gluteal area. When

Previous Therapy

32 _____ Salicylates
33 _____ Bufferin
34 _____ Sensitivity to Salicylates
35 _____ Steroids or ACTH
36 _____ Gold
37 _____ Vaccine
38 _____ Anti-malarials
39 _____ Vitamin D
40 _____ Special Diet
41 _____

Therapy in this Clinic

42 _____ Hospitalization
43 _____ Gold
44 _____ Anti-malarials
45 _____ Oral Steroids
46 _____ I.A. Steroids
47 _____ ACTH
48 _____ Vaccine
49 _____ Basic Program (Mainly Rest)
50 _____

Results of Gold Therapy

51 _____ Improvement at time of evaluation
1. Complete 3. Mild
2. Moderate 4. None

52 _____ Improvement
1. Grade I 3. Grade III
2. Grade II 4. Grade IV

53 _____ Glossitis
54 _____ Dermatitis
55 _____ Abnormal Blood Findings
56 _____ Abnormal Urine Findings
57 _____ Other changes
58 _____ Use of BAL
59 _____ Gold Salt Dosage
1. less than 300 mg.
2. 300-500
3. 500-1,000
4. 1,000-2,000
5. over 2,000

Response to Steroids

60 _____ Improvement at time of evaluation
61 _____ Osteoporosis
62 _____ Infection during course
63 _____ Ulcer symptoms
64 _____ Cardiac symptoms
65 _____ Cushing's syndrome
66 _____ Addiction
67 _____ Died while on steroids

(68) Complications of Disease

_____ 1. Cardiac
_____ 2. Renal
_____ 3. Periarteritis
_____ 4. Scleroderma
_____ 5. Lupus erythematosis
_____ 6. Amyloid
_____ 7. Purpura

Duration of Treatment

1. Exam or Consult only
2. Less than one year
3. Two years
4. Three years
5. Four years
6. Five years
7. Six years
8. Seven years
9. Eight years
0. Over eight years

69 [ ]

Status at time of Evaluation

A.R.A.

Class	Stage	Activity
1. I	1. I	1. None
2. II	2. II	2. Mild
3. III	3. III	3. Moderate
4. IV	4. IV	4. Severe
70 [ ]	71 [ ]	72 [ ]

Result of Therapy at last Visit

1. Complete Recovery	1. Grade I
2. Moderate Improvement	2. Grade II
3. Mild Improvement	3. Grade III
4. No Improvement	4. Grade IV
73 [ ]	74 [ ]

Patient Name

_____
Number

77 [ ] 78 [ ] 79 [ ] 80 [ ]

Figure 2.

500 mg. had been given, the weekly dosage was modified on the basis of the patient's clinical status. If marked improvement had occurred, the dosage was gradually decreased. Otherwise, the 40 mg. of gold salts was continued at weekly intervals until 900 to 1,000 mg. had been given, and then the weekly dosage decreased as improvement was noticed. Finally, all patients, at the end of the period of decreasing dosage, were given 10 mg. per month for years.

At each visit, prior to injection, the patient was questioned concerning signs of sensitivity,

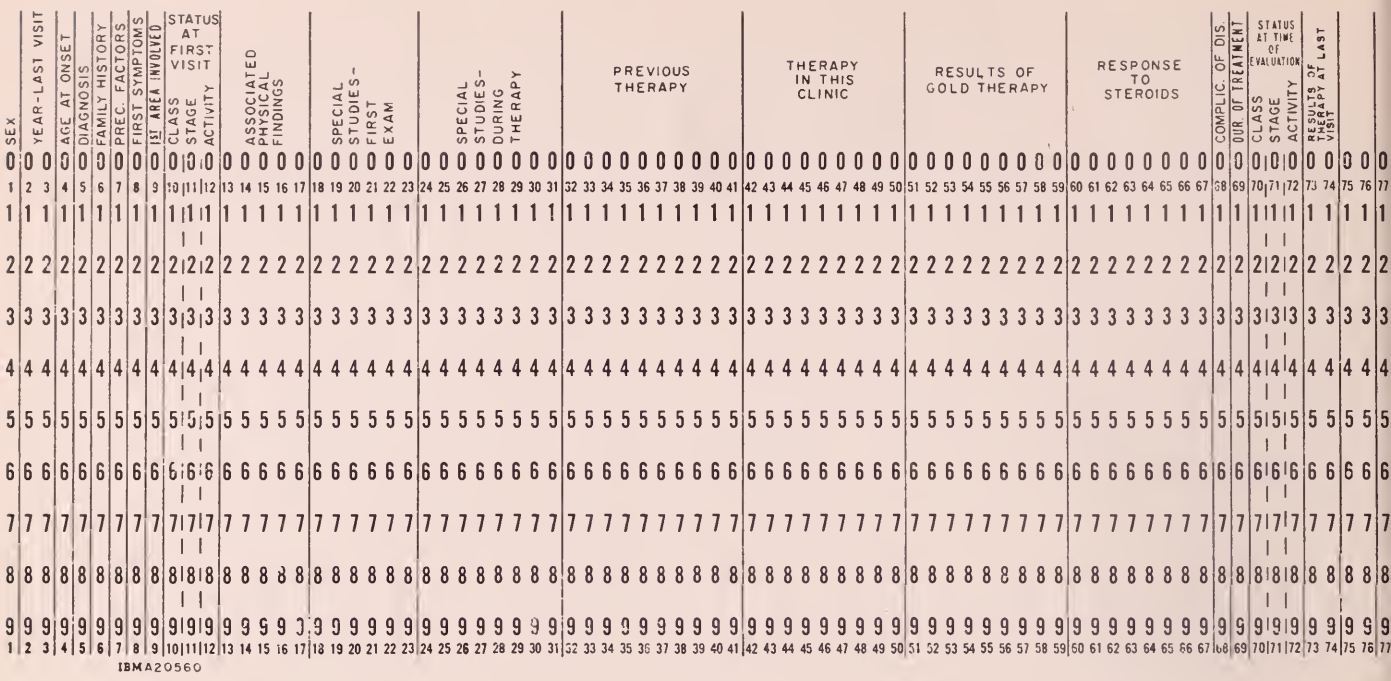

Figure 3.

especially glossitis or dermatitis. A complete blood count and urinalysis were obtained every three or four weeks. With these precautions, any evidence of sensitivity was detected immediately and controlled by decreasing the weekly dosage. If the reaction was persistent, the gold was stopped. There were no deaths in our series. Strict observance of these precautions has been followed, and it is with pride that it can be reported that no serious reactions have been observed. In those patients who have shown some evidence of sensitivity, at least 50 per cent are able to resume gold salt therapy on a reduced dosage schedule.

The data obtained as a result of this study are best summarized in tabular form.

Total Group Comparison

Response to Treatment	Gold-Treated (min. 300 mg. gold salt)	Controls
Major	213 (57%)	219 (38%)
Minor	130 (35%)	270 (48%)
None	26 (7%)	77 (11%)
	369 patients	566 patients

Summary

Thus it is noted the patients receiving at least 300 mg. of gold salt had 19 per cent better chance of complete recovery or of major improvement. It also has been our experience that gold salt therapy may be continued over a period of many years. If evidence of sensitivity occurs, when it subsides, further gold salt treatment may be continued in 50 per cent on a reduced basis. No serious or fatal reactions have been observed in our group of patients.

40 North Street.

Mucoceles: Their Diagnosis and Treatment

James R. Chandler Jr., M.D.
MIAMI

The incidence of mucoceles of the frontal and ethmoid sinuses is infrequent, but not especially rare.

The characteristic clinical picture presented by mucoceles facilitates the task of rendering a diagnosis. Because of the encroachment of mucoceles on the orbit, patients usually first consult the ophthalmologist. If the diagnosis is made early, the operative intervention required is not extensive, a fact which favors the minimizing of deformity and the likelihood of a more successful result.

Definition

A mucocele is a collection of thick mucus which fills a sinus with erosion and some destruction of its osseous walls. In most instances, the color of the thick mucus varies from white to dark green, and its appearance is like that of axle grease. White creamy material suggests pus which may or may not culture out organisms. More commonly, the material is sterile. A definite distinction should be made between typical mucoceles and cysts containing serous fluid without erosion of bone. Cysts may occur in any sinus, although more commonly in the antrum, and should not be confounded with true mucoceles.[1]

Almost invariably mucoceles involve the frontal sinus though they do not necessarily originate there.[2] There have been sporadic case reports of mucoceles involving or originating in the antrum[3] or sphenoid sinus,[4,5] but the anatomic relationships described, the nature of the contents of the cyst, and the lack of histologic proof of its lining membrane suggest that these lesions were not true mucoceles. It is common belief that mucoceles originate in an ethmoid cell, secondarily expanding to the frontal sinus. Clinically, however, the large majority of mucoceles should be assumed to have their origin in the frontal sinus.

Enlargement of the osseous confines of the involved sinus cavity is a prerequisite for the diagnosis. Indeed, destruction of one of its walls and encroachment upon adjacent soft tissues are features that typify the clinical diagnosis of mucoceles. Prior to this development, the processes, unless infected, are completely asymptomatic.

Etiologic Considerations

Goblet cells and mucous glands are a normal component of the respiratory epithelium lining the paranasal sinuses. A mucocele, in common with all other cysts, is certainly the result of a secreting membrane lining a closed cavity. The origin of this membrane may be either that of the sinus itself or the result of obstruction of one of the ducts of a mucous gland. I am inclined to the view that in most patients it is the former, though it has been pointed out that a mucocele does not always fill the entire frontal sinus.[2] It is nonetheless difficult to understand how the bony floor of the frontal sinus can be eroded completely by a cyst within the sinus which has not yet expanded sufficiently to fill the entire cavity.

Obstruction of the nasofrontal duct by any means provides the essential steps for the development of a mucocele: a secreting membrane and no exit for its secretions. This fact explains the pronounced predilection for involvement of the frontal sinus. Its duct is relatively long and tortuous and may become occluded by various causes. Osteomas, deviation of the nasal septum, hypertrophied middle turbinates and ethmoid bullae, previous intranasal and external sinus operations, polyps and hyperplastic mucous membranes secondary to chronic nasal and sinus infections, and external trauma are some of the likely causes of obstruction in the concerned area. Even Paget's disease has been mentioned as a responsible factor.[6]

The sphenoid and maxillary sinuses with their ostia, which are relatively large openings in their anterior and medial walls, respectively, are not very likely to become obstructed in the manner previously described. The ethmoid labyrinth presents a somewhat different situation, but in general, has no ducts as such, but ostia which communicate freely with each other and the nasal cavity. It is believed by some workers[2] that the ethmoid cells may become obstructed and develop

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Read before the Florida Society of Ophthalmology and Otolaryngology, Bal Harbour, Miami Beach, May 2, 1959.

mucoceles, but that these processes expand upward into the frontal sinus and present themselves in the typical fashion already recited.

Microscopic examination of the lining of a mucocele usually reveals patches of ciliated respiratory epithelium scattered among cuboidal and pseudostratified nonciliated columnar epithelium. Even in those mucoceles definitely nonpurulent and sterile on culture, inflammatory cells consisting mainly of lymphocytes and plasma cells are found to be prominent. In some instances, many mucous glands are seen, and in others, few or none. The histologic appearance of the lining in most of the subjects supports the view that the mucosa is that of the former frontal sinus.

Diagnostic Aspects

Since most mucoceles develop in persons with no pre-existing nasal or sinus disease, the patient's complaint is merely that of a painless swelling of the upper eyelid. The swelling appears insidiously and enlarges very slowly. In some persons the history of nasal obstruction owing to polyps or septal deviation can be obtained. Polypectomies and intranasal and external sinus operations may have been performed at some previous time. Trauma to the frontal sinus and region of the nasofrontal duct is occasionally a prominent factor in the history.

Visual disturbances are unusual, except in far advanced or neglected situations, because the proptosis is gradual in onset and slow in development. Diplopia is uncommon although binocular vision may be lost. Occasionally, ptosis of the upper lid will interfere with vision to the extent that this is a presenting complaint.

External examination reveals a characteristic fullness of the upper eyelid in its medial portion with a variable degree of downward and lateral displacement of the globe. There may be residual scars from previous operations. Visual acuity is unimpaired. Palpation discloses a fluctuant, nontender mass which seems to originate from the floor of the frontal sinus just beneath or from the supraorbital rim above the inner canthus of the eye.

Intranasal examination is important, but it may reveal no abnormality. In approximately 40 per cent of patients, however, a clue to the etiology and intranasal extent of the lesion may be ascertained. Polyps with or without pus may be seen in the middle meatus. Indications of previous intranasal operations may be visualized. There may be a large ethmoid bulla, or a fullness involving the bulla and middle turbinate owing to the downward extension of the mass. Posterior rhinoscopy usually proves noninformative, although polyps and pus are sometimes visible. The history previously elicited from the patient often conforms to the findings on examination.

As in other diseases of the nose and paranasal sinuses, the diagnosis of a mucocele is made on clinical grounds. Rarely are roentgenograms helpful other than as confirmatory evidence. They are useful, however, in demonstrating the actual size of the mass, since, like an iceberg, the size of the visible and palpable process is not predictably related to its extent in other directions. The findings vary according to the stage of development, but in most subjects are so typical that the diagnosis can be made from the roentgenograms alone. Perhaps the most constant change is obscuration and obliteration of the medial portion of the supraorbital rim as viewed in the Waters position. The roof of the orbit may appear flattened and displaced inferiorly along its superomedial margin. In addition, the normally scalloped superior margin is smooth and rounded with a halo of increased density. This is observed better on the roentgenogram in the Caldwell position. The over-all density of the lesion itself may be moderately opaque or unchanged from the normal depending on the extent of bone resorption. Aspiration of the contents of the lesion through a large bore needle, and injection of a radiopaque substance will portray more vividly the posterior and inferior extent of the lesion. In selected patients, erosion of the posterior frontal sinus plate can be demonstrated by means of these studies. Although occasionally helpful, I do not advocate this as routine procedure.

The rare mucocele which originates from, or involves the lateral extent of the frontal sinus or a laterally placed orbitoethmoid cell, and presents in the midroof or superolateral angle of the orbit may lead to difficulty in differentiating the process from a cyst or tumor of the lacrimal gland. Usually the former is not so far lateral. By everting the upper lid a portion of the gland can be seen to be separate and movable, as opposed to the mucocele which is more medial and nonmovable. Lesions of the lacrimal sac present low enough to be distinguished easily. Orbital tumors generally arise more posteriorly and do not present a discrete, fluctuant mass in this characteristic location. Osteomas and other tumors of the

bone are distinguished by their hardness and solidity to palpation as are fibromas and other tumors arising from adjacent soft tissues. Epidermoid cysts of the frontal bone may present as typical mucoceles, but usually are quite lateral as well as being uncommon.[7] A meningeal tumor may present in this region to produce some difficulty, but again this is rare. Hemorrhagic cysts simulate mucoceles, but cannot be diagnosed preoperatively.[8,9] Meningoceles present in the midline and are congenital lesions.

Management

Difference of opinion exists concerning the precise type of surgical procedure to employ in the treatment of these lesions. Some workers[10-13] advocate an external approach, though differing greatly on the question of whether or not to preserve the nasofrontal duct, and if so, how. Goodyear[14] stands out as strongly advocating an intranasal approach with preservation of the lining of the mucocele except the removed portion of its floor. He contended that nature cannot be improved upon, and that this is the best possible lining for the necessary drainage tract from the cavity of the mucocele into the nose, and if it is permitted to remain undisturbed, the tract cannot stenose or close. This reasoning is sound and warrants trial by others. Reverchon and Worms[15] reported the cure of a patient after the accidental puncture of the thin intranasal wall of a mucocele by a stylet.

After using the external approach, Simonton[10] recommended complete removal of the lining, but Kaplan, Schwartz and Metson[16] and McNally, Stuart and Childe[17] recommended it only when it is feasible, not objecting at all to leaving some remnants, particularly over dural exposures. Tubes of rubber, acrylic and tantalum have been used to drain the operative cavity intranasally through the anterior ethmoid with or without an anterior or complete ethmoidectomy and removal of all or a part of the middle turbinate. Goodale[12] originated the use of a tantalum foil sheet to prevent adhesions between the orbital contents and the nasal septum and medial portion of the operative cavity. More recently, Goodale and Montgomery[18] advocated the use of the osteoplastic flap for improved exposure and the implantation of fat to obliterate completely the cavity.

That none of these procedures has been uniformly or even highly successful is well known, a fact which gives one pause seriously to consider Weille's report.[13] At a leading training institution, the failure rate for external sinus surgical procedures, that is, for those necessitating additional surgical intervention, was 34.5 per cent.

If this discouraging rate is to be improved, it is my opinion that several prerequisites are necessary for the correct handling of these lesions. The following three essentials are indicated:

1. An external approach for adequate exposure and visualization;
2. Complete removal of the lining of the mucocele;
3. Establishment of wide drainage into the nose by removal of the entire anterior ethmoid labyrinth and the middle turbinate.

The operative procedure followed is essentially that described so well by Lynch[19] in the original description of the procedure which bears his name.

Operative Technic

Intratracheal anesthesia is preferred. The eyelids are closed with a mattress suture over bolsters of 1 cm. sections of ⅛ inch rubber band. A curvilinear incision is then made in the upper eyelid beginning just below the eyebrow at its medial third and carried around the inner canthus of the eye about midway between it and the midline of the nose. Preliminary infiltration of Xylocaine solution, 1 per cent (with epinephrine), aids significantly in hemostasis. Depending upon the size of the lesion, the incision can be extended laterally into the eyebrow through its full extent or over the bridge of the nose into the other eyebrow. If necessary, further exposure superiorly can be had by extending the incision vertically in the midline of the forehead. One should not hesitate to divide the supraorbital vessels and nerve. The small incision is practically indiscernible, and even its extensions do not prove objectionable.

In elevating and freeing the periorbita from the mucocele, an effort should be made to prevent opening into it, as long as possible, since this aids the somewhat difficult dissection at this point. The anterior ethmoid vessels are identified, silver-clipped and divided. Extreme care must be exercised at this point not to tear the periorbita because this location is the likely one for this mishap. The resultant protrusion of orbital fat into the operative cavity interferes with vision and contributes to undesirable postoperative granulations. The dissection is carried back to the pos-

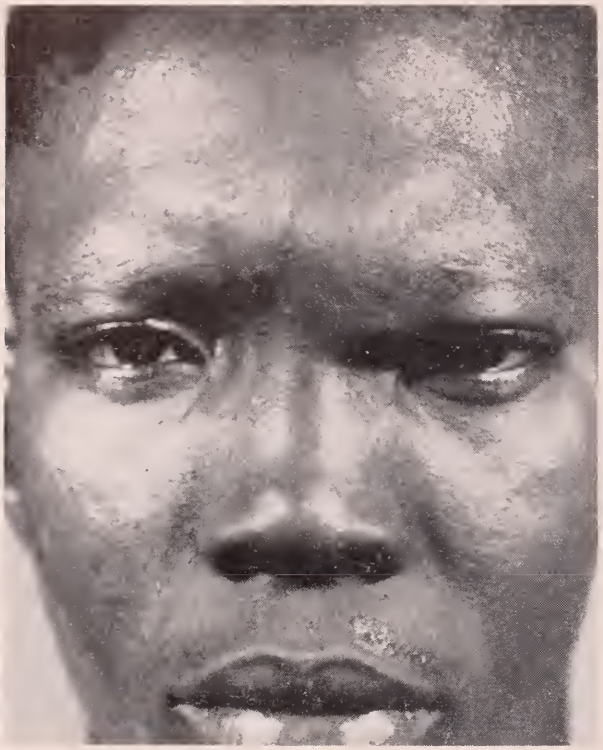

Fig. 1.—Characteristic location and appearance of mucocele.

Fig. 2.—Note clouding of antra, absent right frontal sinus and large area of bone erosion superomedial to left orbit.

terior ethmoid vessels which remain undisturbed. The trochlea is not identified as such, but in elevating the soft tissues in this area, all manipulations are made directly on bone. If this precaution is pursued, postoperative diplopia will be minimal or absent. Inferiorly, this lacrimal sac is elevated gently out of its fossa to expose the entire medial wall of the orbit.

At this point, the mucocele is entered and its extent noted. In approximately 50 per cent of the patients, a dehiscence in the posterior frontal plate is observed. Meticulous removal of the lining of the mucocele is now accomplished, exercising special care to remove its every vestige. Problem areas are lateral and posterior extensions into narrow crevices, superiorly in the case of large lesions, and over the dural exposures where the two membranes are closely adherent to each other.

If there is any question concerning the superior extent of the lesion, a portion of the anterior sinus wall can be removed. In doing so, at least 1 cm. of bone at the supraorbital rim should be preserved so that no deformity will develop. The periosteum over this strip of bone must also remain intact to avoid possible bone necrosis, because the blood supply is derived from the periosteum. Use of warmed laryngeal mirrors is helpful in assessing the superior reaches and the state of very large cysts.

Since in most patients, the nasofrontal duct has been completely distorted and even destroyed by the lesion, it is not identifiable as such and need not concern the surgeon. As Weille[13] described it, this area is the constricted area in the "hour glass" appearance of the final operative cavity.

The complete floor of the frontal sinus should be removed. Posteriorly and laterally in the roof of the orbit, caution should be taken that there is no overhang of bone in relation to the orbito-ethmoid cells with possible residual fragments of mucous membrane. With a Spratt mastoid curet, all ridges must be lowered and removed, permitting a smooth surface to remain in all directions. In the hands of experienced operators, motor driven burrs have proved satisfactory for the conduct of this procedure.

All ethmoid cells, the middle turbinate, and the paper plate of the ethmoid anterior to the posterior ethmoid vessels and nerve are removed. The mucosa of the septum must not be injured.

In patients with pre-existing, extensive suppurative and polypoid sinus disease, the remaining ethmoid cells are removed, and also the anterior face of the sphenoid sinus, its lining and contents. Commonly, a Caldwell-Luc operation is performed at the same time.

The operative cavity is then packed loosely with petrolatum-impregnated gauze brought out through the nose. The incision is closed with fine subcutaneous and dermal sutures and a mild pressure dressing applied for 48 hours. The eyelid sutures remain in place until the packs are removed and the dressing abandoned. Sutures are removed in four to six days. Postoperative antibiotics are administered routinely for seven days.

These patients run a comfortable postoperative course and leave the hospital on the sixth to tenth postoperative day. By this time, the proptosis has largely subsided except for some edema of the lid, which may persist for perhaps 10 days longer.

Report of Representative Cases

Case 1.—A Negro man, aged 21 years, presented a history of nasal obstruction of 10 years' duration. Intranasal polypectomies had been performed in 1952 and in 1953. Two months prior to admission, a swelling developed above the left eye. Purulent nasal discharge and complete nasal obstruction had persisted.

Examination revealed a 1.5 cm. cystic swelling in the left upper eyelid displacing the globe downward and outward. Polyps and pus completely filled both nasal cavities and choanae (fig. 1). Roentgen studies revealed clouding of all sinuses with some bone erosion in the roof of the left orbit (fig. 2).

At operation on May 26, 1958, at Jackson Memorial Hospital, a cyst containing 45 cc. of white, creamy material was found. There were erosion of the sinus floor and a 6 cm. dural exposure posteriorly. Polyps and pus were present in all the sinuses. The entire floor of the frontal sinus was removed and all anterior and posterior ethmoid cells and their contents exenterated. The anterior wall of the sphenoid sinus and its contents were removed and a Caldwell-Luc procedure performed. Culture of the mucocele's contents revealed a variety of micrococcus, coagulase-negative.

Petrolatum gauze packs were removed on the first and second postoperative days. The postoperative course was uneventful, and the patient was discharged on the seventh postoperative day. On September 18, an external fronto-ethmosphenoidectomy and a Caldwell-Luc procedure were performed on the opposite side. He has been well and asymptomatic since.

Case 2.—A white man, aged 78 years, had first noticed a swelling just above his left eye about two months prior to admission. The swelling gradually increased in size until the patient consulted an ophthalmologist because it interfered with his vision. The lesion was aspirated twice with prompt recurrence, after which the patient was referred for further treatment.

There was no history of previous sinus disease.

Examination revealed a soft, 4 cm. cystic mass just above the left inner canthus. The mass protruded below the supraorbital ridge and displaced the globe outwards and downwards. Intranasal examination revealed no abnormalities (fig. 3). Roentgen studies disclosed poorly defined margins of the frontal sinuses with some clouding of both, more pronounced on the right (fig. 4).

At operation on March 28, 1958, at Jackson Memorial Hospital, the cyst was found to contain about 45 cc. of white, creamy material. Also, there was erosion of the intersinus septum and the floor of the frontal sinus. There was a 6 cm. dural exposure posteriorly. The lining membrane was completely extirpated, and the entire anterior ethmoid labyrinth and anterior two thirds of the middle turbinate were removed.

A loose petrolatum gauze pack was removed on the second postoperative day. Contents of the cyst were ster-

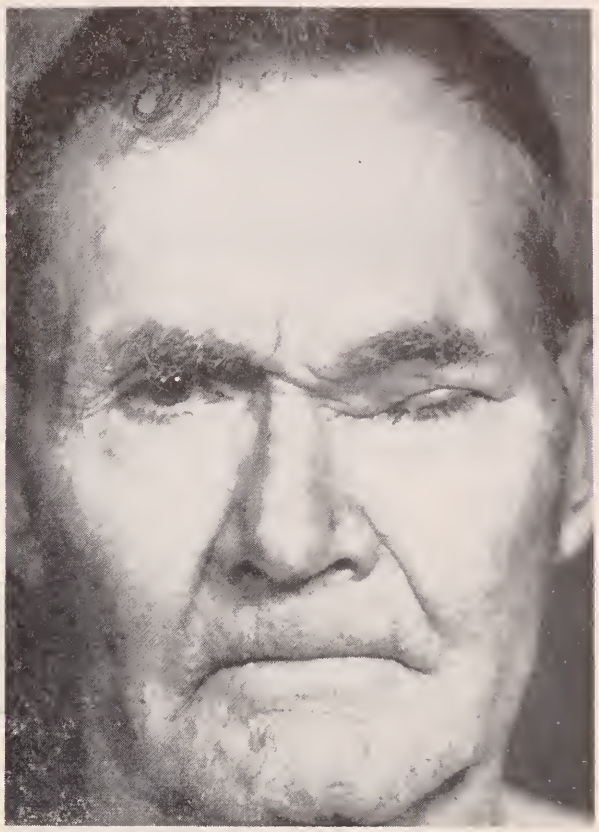

Fig. 3.—Characteristic location of mucocele but with complete closure of left eye due to involvement of upper lid.

Fig. 4.—Note the pathognomonic downward and lateral displacement of the superomedial border of the left orbit.

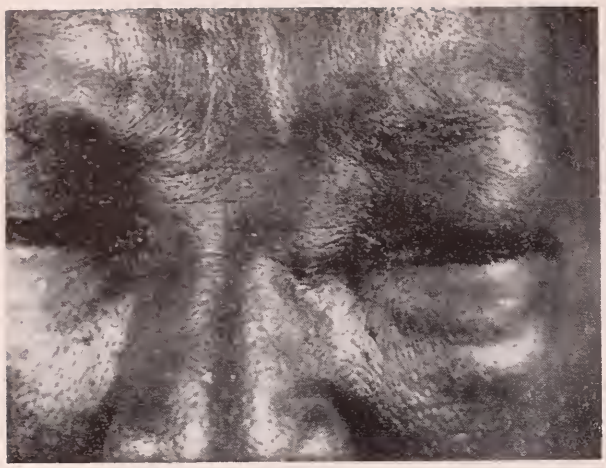

Fig. 5.—Typical location of lesion through unusual extension medially in glabellar region.

Fig. 6.—Note clearly defined area of bone absorption practically in midline with involvement of both ethmoid labyrinths and disappearance of normal cribriform plate contour.

ile on culture. The postoperative course was uneventful, and the patient was discharged on the sixth postoperative day.

One month postoperatively, some edema of the lid and tenderness over the operative site developed. The temperature was 100.4 F., and slight amounts of pus were seen in both sides of the nose. He was treated with Achromycin and nose drops for six days with prompt disappearance of all signs and symptoms. He has been completely well since.

Two months postoperatively, he underwent a successful cataract extraction in the ipsilateral eye.

Case 3.—A Negro woman, aged 55 years, first noticed a swelling between her eyes at the root of her nose about five weeks prior to admission. Gradual increase in size with some tenderness occurred. She was seen first in the Eye Clinic and then referred to the Ear, Nose and Throat Clinic. She had complained of intermittent frontal headaches for five years.

Examination revealed a 4 cm cystic mass between her eyes in the glabellar region. Intranasal examination revealed a prominent left middle turbinate, but otherwise was not unusual. The remainder of the examination gave negative results except for a 2 cm. nodule in the left lobe of the thyroid gland (fig. 5). Roentgenograms revealed erosion of bone in the glabellar and frontal region (figs. 6 and 7).

At operation on Sept. 19, 1957, at Jackson Memorial Hospital, extensive bone destruction in the frontal and glabellar regions was found to be due to a large cyst containing approximately 3 ounces of dark green, thick viscid material which looked like heavy motor oil. A good portion of the nasal bone and nasal process of the frontal bone was absent anteriorly. Inferiorly, the entire floor of the frontal sinus was absent as well as all the cribriform plate area and the superior third of the nasal septum. Both ethmoid labyrinths were completely replaced by the lesion. The dural exposure in this region was 4 cm. in diameter.

The entire lining was removed with many filaments of the olfactory nerves being severed in the process. Many small discrete cerebrospinal fluid leaks resulted. A small isolated, right frontal sinus was found, its floor removed and 5 cc. of thick mucus evacuated. This was thought to represent a second incipient mucocele. Gelfoam was placed over the cribriform plate area and maintained in position by carefully placed petrolatum gauze packs brought out through both sides of the nose. Culture was sterile.

The postoperative course was uneventful. The last pack was removed on the seventh postoperative day. The patient was transferred to the Surgical Service five days later for excision of the thyroid nodule.

She has remained well since her operation, but has been reluctant to come in for the advised plastic restoration of her normal facial contours (fig. 8).

Fig. 7.—Lateral view showing destruction of nasal bones and nasal process of frontal bone.

Summary and Conclusions

A mucocele is a collection of thick mucus which fills a sinus cavity. It is associated with erosion and some destruction of the osseous walls of the accessory sinus cavity.

Obstruction of the nasofrontal duct by any means provides essential steps for the development of a mucocele: a secreting membrane and no exit for its secretions. This very fact explains the pronounced predilection for involvement of the frontal sinuses. Because of their large ostia, the sphenoid and maxillary sinuses are not so likely to become obstructed.

Diagnostically, the history is that of a painless, slowly enlarging swelling of the upper eyelid. There may be symptoms and signs of previous nasal or sinus disease. In some persons, intranasal or external sinus operations may have been performed at some time. Since the diagnosis of a mucocele is made largely on clinical grounds, roentgenograms have only limited value. They should not be omitted, however, in the steps leading to a comprehensive diagnosis.

The management of mucoceles is by surgical intervention, the technic of which is detailed in the text. The objective is to eradicate the mass with minimal external deformity.

Fig. 8.—Postoperative deformity. Except for the removal of sharp edges, no bone was removed anteriorly. Note insignificant scar of incision.

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Volume XLVI
Number 7

Plastic Surgery of the Breast

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The normal female mammae, with the primary function of lactation for feeding the young, can be defined scientifically as two hemispheric sacs of skin filled with adipose and glandular tissue lying within the superficial fascia on the front of the chest wall between the second and sixth ribs. Just below center of each eminence is the mammary papilla which is composed of erectile tissue, encircled by a pigmented areola and perforated by many lactiferous ducts. Artistically, the ideal normal female breast can be described as coned in contour, smooth in tone, gracefully symmetric, delicate in coloring, and through the ages an inspiring subject for poet, artist and sculptor.

In relatively recent years in this country breast feeding has been largely replaced by bottled formula. Thus it might be said breast focus has shifted from the functional to the cosmetic. It is natural that all women would prefer to have breasts of normal size and shape, but with this increase in importance of breast appearance, this desire has been intensified until in some it is almost an obsession. The surgeon's duty does not seem to be in opposing or justifying this trend but rather in surgically assisting, within reasonable limits, those who are uncomfortable, unhappy or severely psychologically disturbed.

Virginal Hypertrophy

In the extreme form of virginal hypertrophy breasts so tragically huge develop in a teen age girl that normal activity is severely curtailed. Not only does she suffer from backache, poor posture and a drag on her spirit but in dancing, riding, swimming or tennis the momentum of her mammae becomes an actual hazard. This is a condition in which surgical correction is indicated, but out of respect for the blood supply to the nipple and skin, reduction and reshaping are carried out in two stages (fig. 1). In the first stage a block of glandular tissue is removed from the upper center of the breast and the nipple is lifted into its correct position.[1-3] The skin is draped about the gland and the excess trimmed so that a vertical and inframammary closure is obtained. Several months later a wedge of gland and skin from the lower pole is excised to complete the reduction and taper the cone.[2,3] Although these hypertrophied breasts usually lactate poorly, the nipple and a sufficient number of its ducts are left intact so that what function is present remains undisturbed.[4]

Ptosis

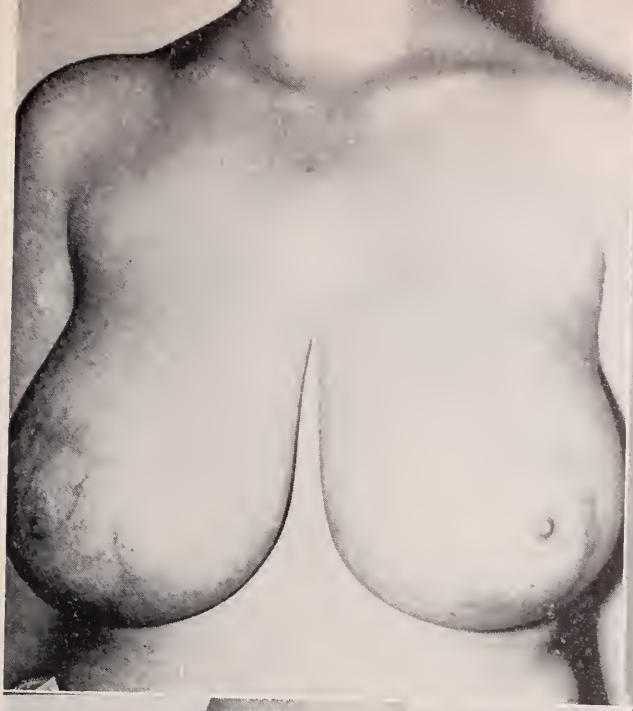
The natural sloping uplift of the virginal breast depends on many fibrous suspensory ligaments which act as a multitude of Lilliputian guy wires. Any condition such as lactation, excess weight, hypertrophy or age which causes the rupture or gradual stretching of these ligaments will eventually produce a ptosis. A ptosed breast can be lifted. The skin is freed from the breast leaving the nipple on the gland in the usual manner. A midvertical through and through incision in the gland which is closed in transverse direction has been found to lift the nipple in direct proportion to the length of the incision. The breast can be further coned by gathering its sides together beneath the nipple in a midline closure. The skin is then draped and trimmed along the routine vertical and inframammary lines (fig. 2). If the ptosed breasts are large, they can also be reduced and lifted in one or two stages as described for virginal hypertrophy. In women over 45 years of age with large pendulous breasts amputation reduction and wedge reshaping are safer from the vascular viewpoint. The nipple is meticulously sutured over the point of the new cone as a free full thickness graft.[5,6]

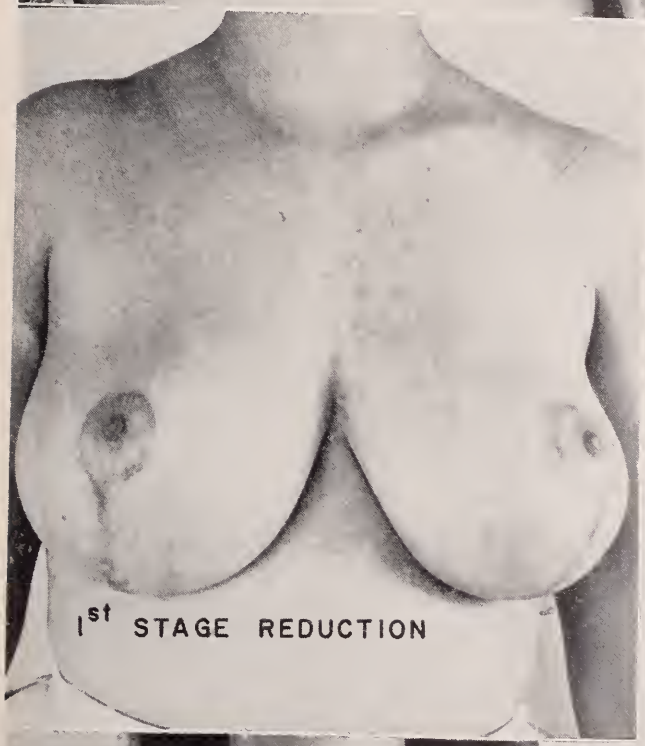
Asymmetry of the Breasts

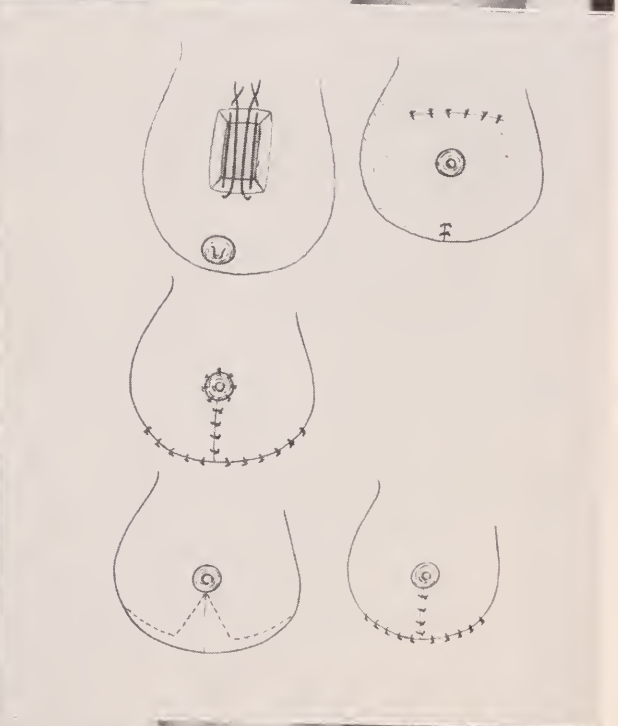
Any form of asymmetry can give a patient a sense of unbalance, a feeling of lopsidedness which can be most disturbing psychologically. Asymmetry of the breasts may be congenital, postoperative or traumatic, and each type deserves reconstructive consideration (fig. 3).[7] Congenital asymmetry could call for a build-up of the hypoplastic side or a reduction of the hypertrophied one. Reconstruction of a breast following mastec-

Opposite

Fig. 1.—Virginal hypertrophy reduction in two stages. 1. Upper reduction and nipple lift. 2. Lower pole wedge resection for shaping.




1st STAGE REDUCTION



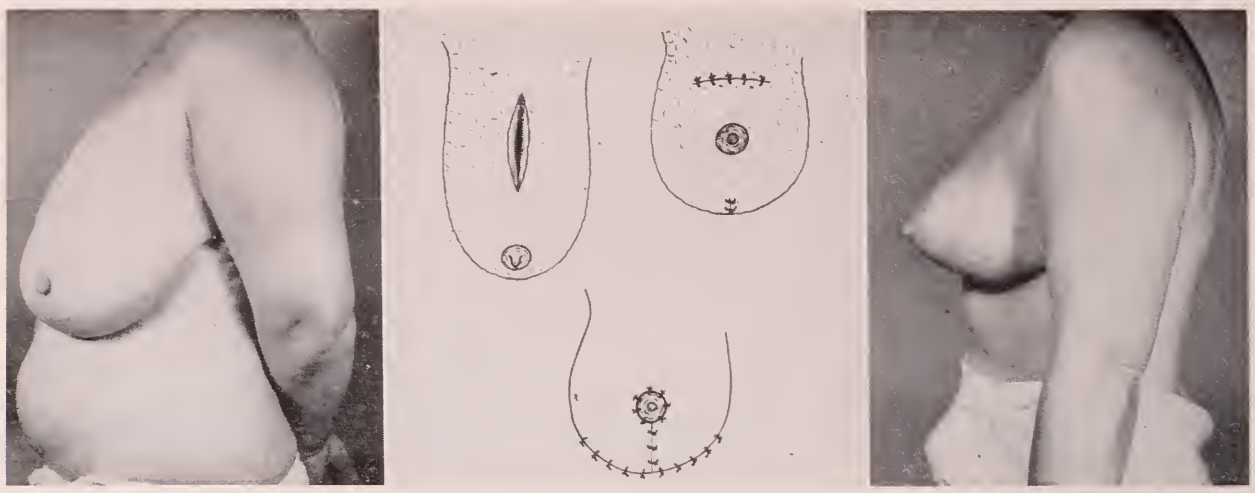


Fig. 2.—Ptosed breasts receive a lift. The nipple is left on the gland, and a transverse closure of a vertical incision in the gland lifts the nipple. The skin is trimmed and fitted like a "bra" with a vertical and inframammary closure.

tomy is entirely possible and even indicated after removal of a benign lesion. Reconstruction following excision of a malignant lesion is more controversial and deserves a separate and more extensive discussion. Suffice it to suggest here that in selected cases of a slow-growing tumor which has been detected early without node involvement in a young woman anxious for correction of her mutilation, reconstruction has been found justified.

Gynecomastia

A large breast is a female sex characteristic and strongly associated with femininity. Thus enlarged breasts in a male can be a source of unending embarrassment. Benign gynecomastia can be reduced through a semicircular intra-areola incision.[8] A thin layer of fat should be left on the under surface of the skin flap to insure an even natural effect. A postoperative pressure dressing and, if necessary, a drain through one corner of the semicircular incision will help to alleviate the accumulation of hematoma beneath the flap.

Hypoplastic Breasts

Propaganda and Marilyn Monroe have so overemphasized the importance of big breasts that even girls with normal breasts are coming down with inferiority complexes. Magazines, movies, television and cartoonists lean heavily on huge breasts for sales. Under these distorted conditions, imagine the psychologic trauma of a girl with hypoplastic breasts.

The best and safest method of permanent breast build-up is with flap tissue. This requires the time and expense of several surgical stages and more extensive scarring. Then, too, the slender type of patient requesting this procedure usually does not have the excess fatty tissue available for an effective double pedicle build-up. Dermolipomatous grafts from the buttocks or abdomen produce exciting early results, but with absorption as the months pass away, so does the new contour.[9]

The popular approach has swung to foreign body implants.[10-13] This has always been the royal road to contour building, but one must tread cautiously for over the long haul it has usually turned out to be a treacherous route. Everything from the "wishbone" of a chicken for a collapsed nasal bridge to paraffin injection for eyelid wrinkles has been tried and discarded. Modern plastic sponge material, such as Ivalon, seems to be relatively inert and easy to shape, insert and maintain in position. Only a 4 cm. incision is necessary and can be placed in the inframammary line or along this line laterally toward the axilla. Once the pectoral fascia is incised, two finger dissection can open a bloodless pocket beneath the fascia for the introduction of the implant.[12] This theoretically prevents the foreign body from ever coming in contact with breast tissue.

Ready-made disks, cups and complicated fluid-filled hemispheres are architecturally unsatisfactory. The contour produced is a rude jutting rather than a natural sloping curve. It is suggested that the implant should be shaped thickest at the lower portion and over its upper two thirds should be hollowed and thinned out to produce a slope rather than a convex bulge (fig. 4). The shaped sponge is soaked in antibiotic solution, inserted into the pocket and the wound closed in several layers. A gentle pressure dressing is applied to discourage hematoma or fluid formation. If fluid does accumulate, it can be tapped aseptic-

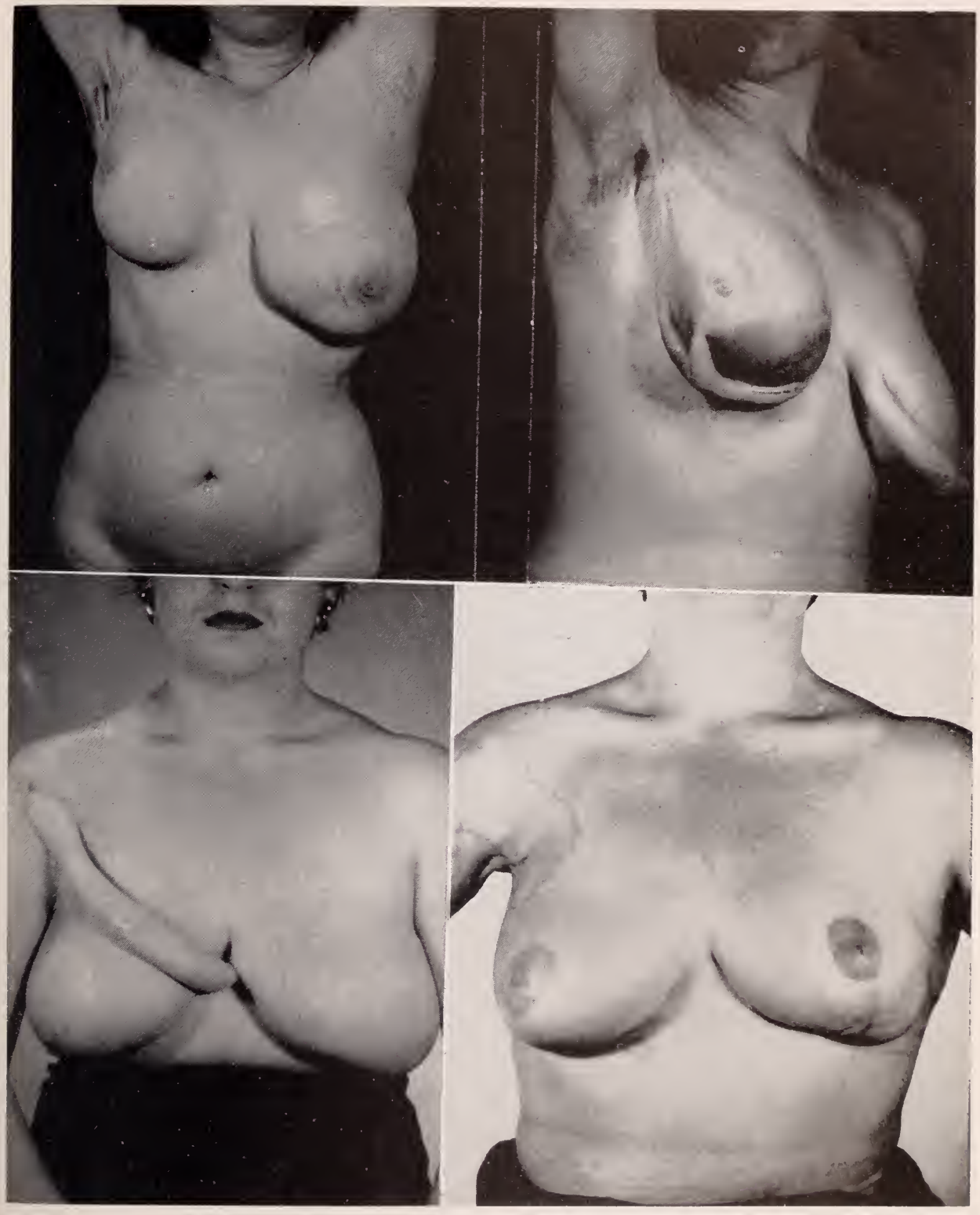


Fig. 3.—A childhood burn caused contracture of the axilla and asymmetry of the breasts. A tube pedicle from each breast contributed to the axillary reconstruction and the breast reduction. A mammaplasty reshaped the breasts.

ally with needle and syringe. During the early postoperative course the breasts are moderately swollen, and engorgement of the superficial veins may occur. Eventually, the dilated veins improve, and what breast tissue lies over the implant will partially buffer its abnormal firmness, but on palpation these breasts can never be said to feel normal. An occasional patient even reports discomfort when lying or sleeping in prone position.

If a relatively inert, sterile foreign body is implanted deep enough and is surrounded by healthy tissue, the body, after a meager attempt

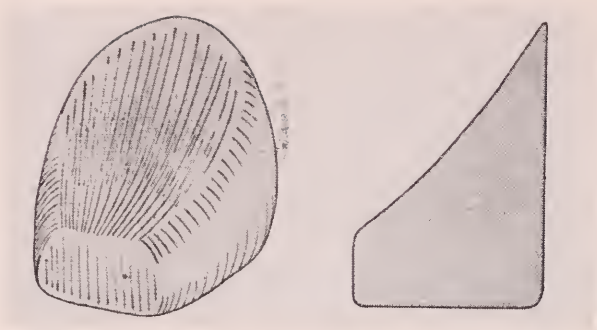


Fig. 4.—Shaping the sponge is important in obtaining a normal-looking breast. Previous publications show unnatural bulges after augmentation.

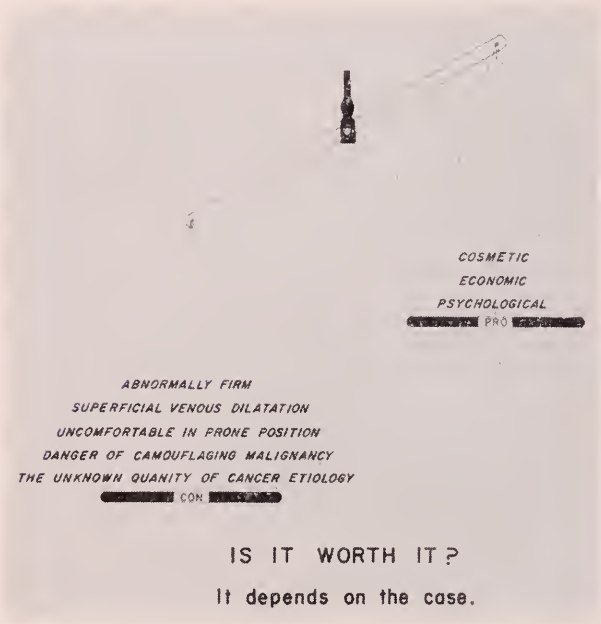


Figure 5.

to throw it out, will wall it off with a fibrous capsule and "forget" it. Ivalon was first implanted in dogs 10 years ago.[14] It has been used in humans for at least seven years, and recently I examined a patient who had had "plastic" implants inserted six years ago. Other than their firmness beneath the breast tissue there was no evidence of irritation. A patient who had received Ivalon implants beneath her breasts in Europe came in 11 months later requesting removal of the sponges. She reported that her right breast had been asymptomatic, but her left breast had drained during the past 10 months. The implant beneath the right breast showed little reaction, but was removed with difficulty due to the fibrous tissue invasion of the sponge. The implant under the left breast was found to be lying very close to the incision and came out easily. This finding suggests the importance of deep burial of these implants to give the tissues a chance to wall them off.

To the present date no reports have indicated that cancer has occurred in the human due to the presence of this foreign body. This absence of reports does not, however, rule out the possibility. A greater danger perhaps lies in the chance that the appearance of an unassociated malignant lesion of the breast might be camouflaged by the presence of the implant so that early detection is delayed. A history of cancer of the breast in the family or the presence of any known breast disease in the patient must be a contraindication for the insertion of these implants (fig. 5).

All patients are discouraged, and all disadvantages are explained and emphasized. Any patient receiving these implants should be followed regularly with check-ups. Thus if an un-

Fig. 6.—Extremely hypoplastic breasts augmented by Ivalon sponge implants to give natural effect.

Fig. 7.—Contour of ptosed breasts and deformity of rib cage improved by Etheron implant. It is not enough to produce two rude bumps but rather natural gentle sloping breasts.

anticipated complication from this type of implant does occur somewhere in the world, those implants being inserted now theoretically have a seven year safety margin and can be removed immediately. Patients receiving these implants under these precautions have been quite happy (figs. 6 and 7).

Summary

Focus on the breast in the United States in relatively recent years has shifted from the functional to the cosmetic, and this trend has increased the demand on the plastic surgeon. The embarrassment and discomfort of abnormally large breasts demand reduction and reshaping. Ptosed breasts can be lifted and asymmetric breasts equalized. Abnormally small breasts can be enhanced in size and contour by the insertion of plastic sponges. Except in selected cases the disadvantages still seem to outweigh the advantages gained with augmentation mammaplasty by sponge implants.

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Number 7

Amputee Rehabilitation

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Not every lower extremity amputee has the motor skills or coordination necessary to learn to use a prosthesis, even though financially it will be possible for the patient to be provided with one. Likewise, the ability to purchase a prosthesis does not mean that it will ever be fitted successfully or used at all, unless certain postoperative and convalescent routines are set up; then specific training to learn to use the prosthesis is arranged.

The veterans from World War II on, have all had the opportunity for the full program of amputee rehabilitation. Only a fraction of the four times as many civilians during World War II, and the yearly increment of civilian amputees since, has had the same opportunity.

Nevertheless, every amputation should be performed at well designated and documented sites of election, and with all the other surgical technics that will make the fitting of a prosthesis efficient, as well as possible.[1-5] The age of the patient is not the determining factor as to the ability to learn to use a prosthesis.[6,7] Proper stump shrinkage and stump shaping; lack of contractures; suture lines and skin grafts where they will not interfere; strength in arms and remaining leg to use crutches; strength in the stump or stumps, to move and control the prosthesis, as well as motor (muscle) coordination, are the determining factors. All of these have to be taken into consideration and provided for if any amputee is a successful limb wearer.

There is a rule, well documented and proved within the past 15 years, that no unilateral amputee, whether the amputation site be above or below the knee, can ever learn to use a prosthesis if he has not the motor skills to learn to walk securely on crutches. There are those of us who have worked with elderly amputees who realize that, if an amputee is not quite secure in walking with crutches on level ground, then, if he cannot also learn to climb stairs using crutches and one hand rail, he definitely does not have the motor skills and coordination to walk securely on a prosthesis. The ability to use crutches securely is the final and determining condition in deciding whether or not a prosthesis should be purchased, no matter if all the other factors have been met satisfactorily, for the unilateral amputee. It takes a minimum of two months, and more often three, to prepare the stump for proper measurement of a prosthesis. It is during this time that the decision about crutch walking is made.

The problem is not so easily solved for the bilateral amputee. The person under 40 or 50 who has a history of at least moderate skills in any physical activity or sport probably has sufficient coordination to balance and control two prostheses. Unless temporary pylons are tried by older persons, the purchase of two artificial limbs for them is more than a reasonable gamble, although some amputees, 70 years of age and older, have learned to use them successfully. The person who has lost one leg, and then comes to a second amputation, will probably be a successful user of the second prosthesis only if he has learned to handle the first one correctly.

Whether a leg is ever procured or not, no amputee should be left a helpless bed patient, or one who is lifted from bed to chair and back again, for the remainder of his or her life. Training in self care—"Activities of Daily Living" (A.D.L.)—is a basic part of all treatment. In the majority of instances in civilian life, a part of the comprehensive rehabilitation program can be planned for, or partially started in the preoperative period. Total treatment includes:

I. Preoperative Preparation
  A. Physical
    1. Decision as to site of amputation
    2. Maintenance of strength in arms and remaining leg (prevention of deconditioning) for:
      a. Activities of Daily Living (A.D.L.)
      b. Crutch fitting and walking training when feasible
  B. Psychologic preparation

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II. Surgery
III. Postoperative Care
  A. Immediate postoperative treatment
    1. Prevention of contractures
    2. Exercises
      a. Arms (and remaining leg) in preparation for:
        (1) Activities of Daily Living (A.D.L.)
        (2) Crutch walking
      b. Stump exercises in preparation for prosthesis
    3. Activities of Daily Living training
    4. Stump bandaging; preparation of the stump for possible prosthesis
    5. Crutch fitting and training
  B. Convalescent preprosthetic training period
    1. Continuation and extension of all immediate postoperative procedures
    2. Activities of Daily Living training
    3. Crutch walking training
    4. Prescription for a prosthesis
  C. Training in use of a prosthesis
IV. Professional Training in Amputee Rehabilitation
  A. Preoperative preparation for amputation
    1. Physical

The traumatic or emergency amputation, with no opportunity to choose the site, occurs rarely as compared to the thousands of amputations performed each year which are decided upon, only after days or even weeks of treatment before it is concluded that an amputation is inevitable. There is not only time to choose the proper site, but also time to carry out some physical as well as psychologic preparation.

I. Preoperative Preparation

Site of Amputation. — Of proved importance is the choosing of the site that will provide for the most efficient use or even reasonable fitting of the prosthesis. The elective sites are well documented in any current book on amputation.[2,3] In this country, an Above Knee or Below Knee site of the proper length can have the most efficient prosthetic fitting. Since the Below Knee (B.K.) stump is not only the easier to fit, but also the easier to learn to walk on, this site is to be preferred whenever feasible over an Above Knee (A.K.) site. The Gretti-Stokes, the Symes, or any other modification of an end-bearing stump is not preferred in the United States. Although done infrequently, no matter how well done, they are too frequently painful and do not lend themselves well to efficient modern prostheses. Similarly, a partial foot amputation is usually more uncomfortable and less efficient than a B.K. amputation.

The Committee on Artificial Limbs of the National Research Council, first appointed during World War II and carried on as a permanent organization, has done a yeoman's service in the development of more efficient prostheses and their component parts. It is on the basis of this continued engineering and medical research that documented sites should be used whenever possible, so that every amputee will have the advantage of being fitted with the most efficient prosthesis, each unit of which has gone through rigid testing before being accepted by the Committee, or put into mass production.

Skin grafts and suture lines that will touch the socket make a comfortable fitting difficult and oftentimes impossible, particularly grafts. Too much soft tissue left at the stump end is sometimes a more difficult problem than is too little tissue, although the latter is also a problem. It is frequently a waste of time and money to keep removing a neuroma, because this tumor tends to recur. Physiotherapeutic measures and/or readjustment of the socket will usually do as well as surgical measures if there is too little skin over the end of the stump. If there is excessive soft tissue as well as a neuroma, a revision may be necessary.

As with choosing the proper site, the surgeon usually has the time to determine all those matters before operating. To obtain even more efficiency, when the surgeon knows his limb maker, and the capabilities of that particular prosthetist, at times a preoperative consultation between the two will make for better results in all ways.

Maintenance of Strength and Prevention of Deconditioning. — Any amount of active exercise of any part of the body improves circulation and prevents deconditioning.[8] Since the majority of civilian amputations are performed because of deficient circulation, exercises of the other extremities should help increase circulation

of the part to be operated on and, postoperatively, should help in the healing of the stump.

The exercises to be done should have a practical use. First among the important self care activities an amputee must learn postoperatively are to move about in bed and then to get from bed to chair without help, whether his condition preoperatively has permitted him to accomplish these activities or not. These can only be done with strong arm extensors, the triceps. Balkon frames and "monkey bars" call only for action of the biceps. This equipment is to be condemned. The amputee, or any other physically handicapped person, needs the biceps only to feed himself and care for such activities as combing the hair or washing. Push-ups, such as for getting on a bed pan or coming to a sitting position, or for getting from bed to chair, which use the arm extensors, are not only practical but time-saving for further postoperative A.D.L. training.

Similarly, maintaining the strength of muscles of the remaining foot, knee extensors and hip extensors, done in both prone and supine position, saves time when the amputee is ready for crutch walking.

If only one leg is affected, and the condition of that leg not worsened or made more painful by short periods of dependency, then it is easier to teach crutch walking before operation. Adjustable crutches should be provided, properly fitted, and the patient taught a tripod gait by someone who knows how to teach crutch gaits.[9,10]

Exercises for the arms and the remaining leg are not purposeful or valuable when the patient is told to "keep moving." They need to be specifically set up by actual demonstration to the patient, or a prescribed number outlined to do once or twice a day, or, as in quadriceps exercise, to work up to 10 times every waking hour in a supine position, to do them correctly. Whenever possible, the exercise should be supervised, if not by the physician, then by a physical therapist working under the doctor's supervision.[11]

PSYCHOLOGIC PREPARATION. — Basically, there must be an acceptance of a change in body image.[12] This cannot usually be accepted in toto until the loss of limb has actually occurred. Also, every pre-amputee must not blithely be promised a limb. Certainly he must be informed that limbs are not purchased over the counter like a loaf of bread, and that the limb will "walk itself."

It is always helpful to bring in a satisfied, well fitted and trained limb wearer, to discuss the problem and possibilities and timing needed to be able to wear a limb successfully. To bring in a poorly fitted and untrained limb wearer would of course be most damaging to anyone's morale.

What not to do, psychologically, is well exemplified in a true story from one of our medical schools. There, a famous surgeon, then Dean of the school, stopped outside a patient's room to lecture his chief resident upon the tact needed to prepare the patient for the fact that an amputation had to be performed. After he had impressed the resident with the great emotional shock the patient would sustain upon hearing this news, they went into the room. Said the Dean: "John, we're going to cut your leg off tomorrow. Dr. Smith here will do it. Dr. Smith, have you ever cut a leg off before?"

II. Surgery

Preliminary planning and prosthetic requirements have been mentioned. The actual operation may well meet all the requirements, but treatment is not complete when the stump is healed, the sutures out, and the bandages removed, then a pair of crutches handed the patient upon doctor's orders, and the amputee discharged to his home as cured.

III. Postoperative Care

IMMEDIATE REHABILITATION PROCEDURES: PREVENTION OF CONTRACTURES. — Excluding the routine postoperative surgical care, the first other immediate problem is the prevention of contractures. Hip flexion and abduction contractures can start in the A.K. stump 48 hours after the operation and these, plus knee flexion, start almost as soon in the B.K. stump.

Elevation of the stump on a pillow or elevation by means of skin traction attachments are the beginning causes of contractures. It is doubtful if these measures prevent or decrease stump edema to any appreciable degree. Sitting all day in bed or chair after the operation also causes contractures, and certainly can add to stump edema by compression of the vessels in the groin. Patients should sit only momentarily to eat, and should spend much of every day and night lying in a supine position if they are to have no hip flexion contractures. Hip abduction immediately follows hip flexion contractures.

Exercises: Arms and Uninvolved Extremity. — If it has not been possible to start the exercises described under Preoperative Prepara-

tion, then they should be started within 24 hours after the operation.

Stump Exercises. — The time when the A.K. amputee can turn into a face-lying position and start hip extension exercises, or try adduction exercises in any position, is the decision of the surgeon. If the suture line is in the proper position, it is doubtful if these two motions will put any strain on the incision, and they could be started earlier than they usually are—perhaps, in some instances, in 24 to 48 hours. Earlier active exercise might even reduce anticipated edema and aid healing by improving circulation.

Quadriceps setting should never affect the incision on a B.K. stump, nor would hip extension.

The earlier stump exercises are started, the less chance of contractures, the less edema, the prevention of muscle deconditioning and the redevelopment of muscle strength. With these, plus stump bandaging, valuable time may be saved for the time when it is feasible to measure for a prosthesis.

Activities of Daily Living Training[13-16]. —The amputee's center of gravity and body balance has shifted with the loss of the limb or limbs. The patient must be taught to move about in bed and turn over without falling out of bed. He never needs to be lifted, once he is out from under the anesthetic. If he has not been provided with "monkey bars" preoperatively, has had some indoctrination in self care, and has had some preoperative training, he will have been, at least psychologically, prepared and motivated to start caring for himself, even with the change in balance.

Sitting up, by using the triceps, dressing, and getting from bed to chair as soon as his surgeon permits, follow in logical sequence in preparation for crutch walking, if he is a unilateral amputee. If a bilateral amputee, then there is even more need to learn self care, and develop strength in the necessary arm muscles.

Stump Bandaging. — There is a scientific way to bandage the A.K. stump and another scientific way to bandage the B.K. one. The A.K. stump is bandaged with two 6 inch nonelastic Ace bandages sewed together. Both methods are well documented.[3,6]

Before any prosthesis can be measured for successful fitting, every stump must be shrunk and shaped into a conical form. This procedure will take at least two months, if not three, of daily, or several times daily, proper bandaging. All the bogginess and edema must be out of the stump before even the initial socket can be made to fit. A bulbous stump cannot be fitted. Commercial stump "shrinkers" have not been as successful in giving the desired shape as is the correct bandaging. When stump shrinkage is done properly along with stump exercises, and contractures prevented, the initial socket should be the final one.

The dressings that are put on after the operation sometimes tend to compress at the top of the bandage. The edema at the site of operation that would physiologically be expected to occur is then kept in the end of the stump by the constriction of the bandage at the top of the dressing. Thus a bulbous stump begins to develop. For many years it has seemed to me that the institution of correct "stump shrinking" bandaging, soon after operation and before the sutures are out, whenever possible and tolerated, would not only speed up the shaping of the stump, but would of itself help prevent some of the edema. It would certainly ward off the development of a bulbous stump, whether a B.K. or an A.K. stump.

The importance and need for correct bandaging to shape the stump properly must be explained to the patient and his family. The one with a B.K. stump can be taught to bandage his own, but the one with an A.K. stump always needs help. The A.K. stump will have to be bandaged and rebandaged at least twice every 24 hours. Since the more efficient the bandaging and stump exercises, the sooner the stump can be measured for a prosthesis, supervision a minimum of five days a week is time-saving.

My associates and I prefer to have a therapist put the bandages on once a day when the amputee comes for his daily treatments. We ask a relative to come and learn how to do the bandaging and also send mimeographed diagrams of the procedure home with the amputee. The home bandage program is not as likely to give the proper tension in all the proper places, but the bandage applied by the therapist will usually stay for several hours and more than counteracts any inadequate bandaging done at home.

Crutch Fitting and Training. — Crutch walking can be started at any time during the immediate postoperative period that the surgeon considers advisable. Opinions vary on when this should be done, and of course the time relates to the possibility of increased edema from depend-

ency and the concomitant possible strain on the incision before the sutures are out. Again, if the proper bandaging has been started, crutch walking can be started much earlier. Without the correct bandaging, the dependent stump maintains its edema far longer, and again delays the time when a prosthesis can be measured.

There is a proper way to fit crutches, and there are seven distinct crutch gaits[9,10] suited to various disabilities, of which the unilateral amputee should use the tripod. All the weight is carried on the hands and never any in the axilla. A pad on the top of the crutch is an immediate indication that the patient has had no proper instruction in crutch walking.

Any crutch walking training is best started in parallel bars in a physical therapy department. If the equipment is not available, then at least a physical therapist should fit the crutches and start the training.

A few nurses have had courses in rehabilitation nursing and have been taught crutch fitting and walking, but nurses with this training are rare outside of large Physical Medicine and Rehabilitation Departments or Institutes of Physical Medicine and Rehabilitation.

For many years, whenever a physician has decided that it is time for any patient, not only an amputee, to start walking on crutches, the routine written order has been "Crutch Walking." The charge nurse has then been accustomed to say to an orderly, or some other messenger: "Go to supply and get a pair of crutches for Mr. X in Room 000." A pair of crutches is then handed to Mr. X, and whoever delivers them says to Mr. X, "The doctor says you are to walk on crutches; so here you are. Get up and do so."

Many a patient has tried, only to fall down immediately, and thus becomes so fearful that he is never willing to try again. I have seen amputees who have sat in a chair for three years or longer, never having tried to walk after their first try, because it was done on the routine and the sequence described. Severe contractures develop as they sit.

Convalescent and Preprosthetic Training Period: Continuation of All The Immediate Postoperative Program. — This is the most important and decisive period in which the entire future way of life of the amputee, especially the A.K. amputee, will probably be decided. Each activity started in the early postoperative period now needs to be watched in even greater detail, and under daily supervision and prescribed activity, in a physical therapy department whenever possible.

The decision to order a prosthesis is yet to be made at the end of this period, but the amputee must be in condition to have one ordered, when and if that time comes. Close supervision during this period is a time-saving device and therefore a period of financial saving for the future. The amputee who is sent home with instructions "to bandage and exercise the stump and in three months get measured for a prosthesis" has to go through this same preparatory period later anyway, if he ever gets a leg to fit properly. Furthermore, it may take a longer period of time to shrink the stump adequately; contractures are usually present, not only from sitting but from the fact that the only exercise the patient knows to use is hip flexion, never hip extension and adduction.

Activities of Daily Living[13].—This training progresses from all bed, chair, eating, dressing, to bathroom activities—either from a chair or on crutches.

Crutch Walking. — This activity is either started, or is continued, so that the patient gains both security and endurance. Once the unilateral amputee can walk securely on level ground, he is graduated to climbing ramps, curbs and stairs. The stair progression should advance through using one crutch and one rail to using no rails at all whenever possible.

Prescription For A Prosthesis[11].—When the unilateral amputee has met the rules of crutch walking and can demonstrate coordination and balance, then when the stump is sufficiently shrunken and shaped, the prosthesis can be measured. The decision as to the time of measurement should be made by the physician, or even better, the physican and the certified prosthetist should make the decision together and discuss the component parts of the limb to be prescribed.

The prescription itself is made by the physician. It should be written, and, starting with the type of socket, the type of knee, foot and ankle are to be specified.

No matter how adequately a stump has been shrunk and exercised, the stump continues to stabilize and change over a period of three to six months after the amputee starts training to walk on it. With sufficient preparation and proper choice of type of socket, the first socket should be quite adequate and satisfactory, for the final changes that always occur are taken into consider-

ation and accounted for when this first socket is "drawn."

A suction socket is fitted without a liner and worn without a stump sock, but lies directly against the skin. Suction cannot be maintained to keep the leg on with a flabby stump, and little or no muscle bulk. While a suction socket tends to increase the muscle bulk eventually, as the stump is used in walking, if fitted while the stump is still flabby, all of this soft tissue must be shrunk away before there is muscle bulk to maintain the suction. Before this happens, a new socket is usually required. Suction sockets usually cost more (around $100 more) than the "Standard" ones for two reasons: (1) it is more difficult to get a proper fit in the first place; and (2) many more adjustments are usually required.

The "Standard" A.K. socket is now usually made with the same quadrilateral shape as the suction socket. The old "plug" shape is used only occasionally. This socket is suspended on a belt through an attached hip joint. Stump socks are worn. Liners, paddings and/or "rimming out" the pressure points make a comfortable fit possible.

The patient starts out wearing one stump sock and no liner, although a liner is routinely made for every socket and included in the initial cost. In the "Standard," the stump continues to shrink in contradistinction to the suction socket. As it shrinks, a second sock is added, but when the shrinkage has progressed to the stage where three stump socks are necessary, then the leather liner is put in and only one sock worn. Pressure points are rimmed out, while any hollowed out areas in the stump are compensated for by padding under the liner. These adjustments are easier to make because, as the stump aligns itself, the changes can be compensated for under the liner. Also, the fit does not have to be quite as accurate in the first place. When a change has been made in the suction socket, once an area is hollowed out, or the stump has shrunk more, there is usually no satisfactory way to correct these changes without a new socket. While occasionally a liner may be used, this is not a very satisfactory expedient.

The "Standard" is more satisfactory for the older person whose tissues tend to be flabby and who is less prone to activity. It is also better for the person who is not close to the shop where adjustments can be made, or for the person who is uncooperative about coming for adjustments, or when the difference of approximately $100 is a matter of importance. Since new sockets of either type also usually cost around $100, it is readily apparent that time and money spent in the initial preparation is money saved. If a leg cannot be worn "because it does not fit" and is put away on a shelf, then all the money of the initial purchase is also wasted.

The actual number of months it takes for the stump to stabilize itself depends upon how much the amputee walks on his prosthesis and how correctly he uses his stump in controlling the prosthesis. The prosthetist who has kept up with the full program of amputee rehabilitation usually includes adjustments over a period of six months in the initial purchase price. One should be suspicious of the ability of the prosthetist who includes only three adjustments in the initial price.

When an amputee presents himself with a prosthesis that has never been adjusted: (1) he has walked on it little or not at all, but worn it mainly for cosmetic purposes; and (2) he has had no training in using the stump to control the prosthesis properly. If this amputee comes in walking on the prosthesis but using crutches, and particularly with underarm pads, this is immediate proof that he has had no training in using the prosthesis; he will have had few or no adjustments, but will frequently complain that the prosthesis was not made properly because it hurts in various places.

Training in the Use of a Prosthesis. — When the prosthesis is completed, it should be delivered to the physician who prescribed it for a check-in, and at the same time or directly after, the patient is sent to a physical therapy department where the training program is initiated under the physician's prescription and supervision.

Training is started in the parallel bars. Once balance is learned, then walking is initiated. Only when a proper walking pattern has been learned in the bars is the amputee graduated to walking outside the bars on two canes. Until the amputee has learned a proper walking pattern, the prosthesis remains in the department. When an amputee is only fitted with a prosthesis and sent on his way, like using crutches without training, and with no knowledge of balance and control of the prosthesis by the stump, he bungles along with an unsightly, unstable and improper gait, and even if the prosthesis does not need adjustments at once, his improper use of the appliance may also be painful. Furthermore, the amputee has no knowledge of when adjustments need to be made; so, between the two situations, a vicious circle is

established that makes for an unsatisfied limb wearer. He may put the limb away on a shelf, or demand that more and more sockets be made, in his rightful ignorance, blaming a poorly made socket because the leg does not walk itself and feel comfortable at all times. Furthermore, if he continues to try to walk, there develops an ungainly walking pattern which will take weeks of proper training to overcome.

When he has the proper training, he progresses from level ground walking to stairs, curbs, ramps, bus steps, or driving a car with a hydromatic shift or hand controls. Many unilateral amputees quickly give up one cane, while some, particularly among the younger people, learn to maintain a good walking pattern using no cane at all.

It is readily apparent, then, that all the care and attention to details go for naught if there are no facilities with trained personnel available where an amputee can have the proper training in the use of a prosthesis. Amputee rehabilitation should be done correctly or not at all.

During World War II, the amputee centers, such as Walter Reed General Hospital, estimated that the average time to allow for training in the use of a B.K. prosthesis was one month; that three months minimum must be allowed for a unilateral A.K. and that much time or longer for a bilateral A.K. or a combined A.K.-B.K. amputee. Balance and stump control for a bilateral amputee is obviously more complicated. In our opinion, pylons should be used only for the elderly amputee, and first as a trial for balance. Since they have no knee joints, the walking pattern learned on the pylons has to be overcome on prostheses, but a proof of balance in these instances is more valuable (or even a financial saving) than the problem of retraining in a proper walking pattern later, if it is proved the patient will be able to balance and walk at all.

IV. Professional Training in Amputee Rehabilitation

All the detailed component factors of amputee rehabilitation are a part of the training of every physiatrist. Physical therapists are taught their part of the training program in every school of physical therapy approved by the American Medical Association.

In addition, for the past few years, starting in 1952, prosthetic education courses have been given several times a year at the University of California at Los Angeles School of Medicine and the New York University College of Medicine. The prosthetist comes for three weeks; the physical therapist for two weeks starting the second week of the prosthetist's course; the physicians then come for the last week. All the courses are intensive, with especially prepared manuals. Problems of fabrication, component parts, fitting, check-out and amputee training are gone into thoroughly. The team approach is well demonstrated. Many physicians other than physiatrists have now taken these courses; many physiatrists have them as part of their residency training and others take them as refresher courses to keep up with the latest accepted (proved) mechanical developments.

Additional courses have now been started or are planned for insurance adjustors and for vocational counselors from the Offices of Vocational Rehabilitation of the Department of Health, Education, and Welfare. Training of these two groups is an important step, for it is undoubtedly these two groups who carry the greatest financial burden since they purchase the most prostheses, rather than individual private citizens. Frequently they purchase one leg, then one socket after another, and still have an amputee on their roles who cannot wear, let alone walk on, the artificial limb.

Summary

This paper summarizes the current modern rehabilitation treatment program for lower extremity amputees. All United States veteran amputees have been benefited by this kind of program, but still too small a proportion of the civilian amputees have had the opportunity to avail themselves of this type of treatment and training, which is, in toto, rehabilitation.

The numerous books and articles written during and since World War II, including the reports from the National Research Council and its publication "Artifical Limbs" and the courses given at the University of California at Los Angeles and the New York University, substantiate this program.

The following statement, which appeared in the April 1958 issue of the Medical Science Journal,[17] sums up what has been said innumerable times elsewhere: "It costs about $3,000 to rehabilitate an amputee so that he can be financially independent. This amount is about five years' income tax for the average citizen. *If the amputee is NOT rehabilitated, he and his family may become permanent public charges* at far greater

cost and with no possibility of repaying the costs through income taxes."

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Volume XLVI
Number 7

Challenge of Tuberculosis

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The closing of the Central Florida Tuberculosis Hospital in Orlando has been reported recently, and this news is heralded by many as indicating that the tuberculosis problem is well under control and well on the way to complete eradication. In the past couple of years the famous Trudeau Sanitorium closed its doors. The death rate for tuberculosis was about 50 per 100,000 population when the Orlando hospital was opened, and we now have a rate of 6.5 in 1958. What more is needed to lead us into a state of complacency than the news that our tuberculosis hospitals are no longer needed and that their doors are being closed?

But do the facts relating to tuberculosis warrant complacency? As Al Smith would say, "Let's look at the record." New cases of tuberculosis in Florida in 1958 totaled 2,226. There were 2,253 new cases found in 1955, and in 1950 the number was 2,337. We picked these years because they appear to show little change in the number of new cases of tuberculosis, but we must admit that there has been a gradual decrease in the number of new cases over the past several years, and the incidence has dropped from 118.7 to 50.0 per 100,000 population in the past 10 years.

The Central Florida Tuberculosis Hospital was opened in 1938, and three new hospitals were opened between 1950 and 1952, giving the combined bed capacity of approximately 1,850. Yet, this did not provide enough beds, and there was a waiting list for admission of patients with active disease. Records show that for the first time in August 1955 there was no waiting list. In the days when there was a waiting list the combined hospital patient census did not exceed 93 per cent of total bed capacity. With the closing of the Orlando hospital the capacity will be approximately 1,450 beds, and it may be that a small waiting list will again appear. The 1,450 beds will not care for a daily census of more than 1,350 patients, and the combined census now rarely drops below 1,400 patients.

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The number of new cases of tuberculosis found does not show the whole picture. When autopsies are performed, active and inactive tuberculosis is found which had not been diagnosed prior to death.[1] Death certificates in the United States have shown that in one fourth or more of the fatal cases due to tuberculosis this disease had not been reported prior to death.[2] In Florida death certificates accounted for 23.4 per cent of the tuberculosis deaths in the past three years. Public health authorities estimate that only 60 per cent of the cases of active tuberculosis in the United States are known. These facts should constitute a challenge to our profession. Because we, as a profession, do not accept this challenge fully or believe there is no challenge, the State Tuberculosis Board must reduce the number of available hospital beds, and to effect this reduction will close the doors of the Central Florida Tuberculosis Hospital at Orlando.

Meeting the Challenge

How can we accept this challenge? If we are to find any of these presently unknown cases of active tuberculosis, we must elevate our index of suspicion. We can take no credit for finding tuberculosis in a person who is acutely ill and has many of the classical signs and symptoms. We should attempt to find each new case while the disease is still minimal when there are no symptoms, at which time the disease is relatively noninfectious and when response to specific chemotherapy is excellent. Such cases will be found as a result of routine examinations of an apparently well person rather than one seeking medical care. Gray and Spencer[3] reported a series of 166 cases of minimal tuberculosis in which only 17.5 per cent of the patients requested medical attention.

We can raise our index of suspicion by doing annual tuberculin testing on every person visiting our offices or clinics or admitted to a hospital. The number of persons with a negative tuberculin reaction is now higher than many physicians believe, and it will become higher each passing year. The tuberculin test will help greatly in differentiation of infiltrates seen on radiography, where the

infiltrates of fungus diseases are being seen with increased frequency. The tuberculin test is highly accurate as a diagnostic tool. We should use it as routinely as we do an examination of the urine. By this method conversion from negative to positive reaction is determined, and if appropriate chemotherapy is used, we believe disease can be prevented. The College of Medicine of the University of Florida and the University of Miami School of Medicine are tuberculin testing medical students and student nurses periodically. Converters will be treated for a year with isoniazid. It is believed one occupational disease of physicians and nurses can be prevented by this means. This procedure should be extended to all hospitals in preventive care for their residents, interns, nursing staff and technicians. A long term United States Public Health study[4] involving 2,750 children in the United States, Canada, Mexico and Puerto Rico showed that prophylactic chemotherapy prevented approximately 85 to 90 per cent of clinical tuberculosis in the first year of the trials, and favorable results were noted in the second year. There is much enthusiasm for this form of preventive medicine, and the belief is held that much of the tuberculosis later in life will be prevented. Many years will be required to establish the proof of that idea.

The use of BCG should be mentioned. It is of proved value in certain situations, but is not recommended for general use. Its value as a vaccine is low. A large scale study[5] by the Public Health Service showed this form of vaccination prevented about 7.9 per cent of the total expected cases. The vaccine cannot be used with positive reactors where most of the disease occurs. It was about 31 per cent effective in the nonreactors. On the minus side it removes the tuberculin test from the diagnostic armamentarium to detect early tuberculosis or to help eliminate the possibility of tuberculosis in diagnostic problems. The protection it may give is only relative and entirely unpredictable. In situations where BCG might be useful the prophylactic use of isoniazid would be more dependable.

If we will help in community efforts to obtain annual roentgenograms of the chest on all reactors and annual tuberculin tests of all nonreactors on all residents of Florida, regardless of age, most of the new cases of tuberculosis will be found early enough to limit the spread of infection to others and in the new case to give the patient the benefit of early chemotherapy. The length of stay in the hospital will be reduced greatly, and the public will not be handicapped by the loss of a tuberculosis hospital.

In addition to the challenge to find new cases of tuberculosis much earlier than we have in the past, there is a responsibility to know current therapy of tuberculosis. Our hospitals are discharging patients much earlier than formerly, which is a fact of great importance. We can treat patients with fewer beds, but when patients are discharged early, someone is responsible for adequate follow-up. We must know what constitutes adequate sputum and roentgen examinations to be able to prescribe the necessary chemotherapy. Today the emphasis is on long term therapy, and the decision to discontinue therapy must be given very serious consideration. If the medical profession does not accept some of this responsibility, the local health departments must assume an ever increasing work load with its increased cost and an aspect of governmental control that we are constantly striving to avoid.

Conclusion

We should consider the closing of the Central Florida Tuberculosis Hospital to be a milestone in the history of medicine in Florida. We will miss it for a while. If we raise our index of suspicion, we will miss it for a longer time. Tuberculosis as a disease can be eliminated by always looking for it in each person being examined, but the threat of the disease will remain as long as there are reactors to the tuberculin test. And as long as tuberculosis exists, we must be more aware of the challenge to find the disease in the person who comes to our office apparently well, who has only minimal disease, who has not yet become a public health hazard and who will respond promptly to proper medical care. We have a responsibility to accept the challenge.

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ABSTRACTS

The Otolaryngologic Aspects of Skin and Scuba Diving. By G. Dekle Taylor, M.D. Laryngoscope 69:809-858 (July) 1959.

This monograph reports extensive original research and presents a comprehensive survey and discussion of the otolaryngologic aspects of skin and scuba diving. A unique contribution to otolaryngologic literature, it emphasizes that it is important for every physician to know the medical problems and the dangers inherent in man's excursions into the subaquatic world. After elucidating the basic factors of diving physics, Dr. Taylor discusses such otolaryngologic problems as pressure factors; aero-otitis media; aero-otitis media and hearing loss, with a report of two cases illustrating this occupational hazard; aerosinusitis; sound transmission; air embolism, with emphasis on the important role of the larynx; and decompression sickness.

A study of 38 skin and scuba divers is analyzed. It includes consideration of barotrauma in flying and diving, with report of a case representing the author's personal experience; nasal bleeding; perforated tympanic membrane, amplified by a report of three cases; dizziness, seasickness, bends, and panic; loss of hearing associated with diving; tinnitus; sinus involvement; appearance of tympanic membrane; miscellaneous observations; and divers' observations. In addition, detailed observations, particularly in relation to temperature changes, on the "mermaids" at Weeki Wachee Spring, Florida, are described, with a report of one case representing the type of person the author thinks should give up diving. Contraindications are reviewed, and in a broad concluding discussion, the importance of carefully supervised instruction and the exercise of sound judgment in the pursuit of skin and scuba diving are stressed. Illuminating the text are excellent illustrations explaining Boyle's law in both skin and scuba diving; aero-otitis media; the glottis in ascent; the mechanism of air embolism, pneumothorax and mediastinal emphysema; barotrauma and tympanic perforation; and barotrauma and ear plugs.

In summary, Dr. Taylor concludes that if man will understand and accept the limitations nature has placed upon him in an aquatic environment, he may learn to adapt himself well to skin and scuba diving, aided by proper methods of breathing and intelligent use of the face mask, fins, snorkel and scuba. Loss of hearing resulting from aero-otitis associated with increased pressure, a relatively infrequent occurrence, results from damage to the middle ear caused by the inability to equalize air pressures. Difficulty in equalizing pressure through the eustachian tube should preclude indulgence in these sports. Air embolism may be a serious complication of scuba diving, and the scuba diver should be well versed in its mechanism and how to avoid it. On being subjected to pressure, one may experience a temporary loss of hearing, which usually subsides completely when the tissues of the middle ear have returned to normal.

Skin and scuba diving are potentially fatal sports, requiring thorough familiarity with the physics and physiology of diving. Pain in the region of the ear and sinuses is probably the greatest deterrent, and ignorance and foolhardiness are the greatest dangers to man's subaquatic adventures. Those who are fearful of underwater and confined spaces and those who are poorly trained in the proper methods of skin and scuba diving and are not fully aware of the limitations imposed upon them by nature should not indulge in these activities for they may experience panic underwater and thus court disaster. Man has adequately demonstrated his ability to adapt himself to a subaquatic environment by means of proper equipment, proper training and proper physical status, but without the benefit of expert experience, and adequate instructions and equipment, he may well destroy himself.

This We Believe. President's Address. By Louis M. Orr, M.D. J. A. M. A. 170:1139-1140 (July 4) 1959.

In this inspiring forthright address delivered on the occasion of his accession to the presidency of the American Medical Association, Dr. Orr sets forth succinctly the fundamental beliefs which are vital to medicine, to America, and to all mankind. He declares that men who blaze the trail for humanity must learn from the past and face up boldly to the future. To do so, they must breathe the air of freedom, and they flourish best where all men respect knowledge, value personal

initiative, and applaud quality. They have flourished in America, whether in medicine, in industry, or in the other professions, because this nation, from its beginnings, has cherished the ideals of individual freedom and self reliance. Reviewing present disturbing trends in this country, he draws a lesson for today from Greece and Rome and their downfall, not from outside aggressors but from a decline in their moral and spiritual strength.

In appraising the road medicine is to travel, Dr. Orr emphatically rejects the road of compulsion and extols the road of the free spirit, the road medicine must continue to follow if it would remain a faithful servant of mankind. His plea is for "not compulsion but voluntary cooperation; not force but reason; not blind obedience but independent intelligence; not timidity but faith—faith in man, faith in ourselves, faith in God." Freedom, he holds, if it is to survive and grow, "must be fought for again and again, day after day, by men and women willing to stand up and be counted." He emphasizes the purpose of American medicine to continue to furnish the best possible health care to every American including particularly the older citizen, to continue to improve and broaden voluntary health programs, and to continue to defend the unfettered mind, for medical progress depends on the relentless quest for truth by minds that are free. The practice of medicine, he declares, "is more—much more—than merely facts and experience. It is new knowledge, new ideas—a blending of the best of the old with the best of the new." This stimulating address vigorously upholds the basic belief that the fundamental obligation of the medical profession is to maintain medicine's role as mankind's faithful servant.

Skin Manifestations of Organic Phosphate Insecticide Poisoning. By Tobias R. Funt. A. M. A. Arch. Dermat. 78:82-84 (July) 1958.

Fatalities due to organic phosphate insecticide poisoning establish undeniable evidence of a relatively new and often baffling menace to public safety. A case is here reported in which a dermatologic finding is presented as a sign of chronic exposure to Parathion, one of the more commonly used organic phosphate insecticides. The author observes that insecticides of organic phosphorous derivatives are highly dangerous poisons to which adults and children are being exposed, the commonest offenders being Parathion and Systox, used as garden insecticides. He reminds physicians to be on guard for the occasional patient with clinical signs of parasympathetic stimulation as the key to a diagnosis of chemical poisoning. Signs include miosis, paradoxical mydriasis, localized hyperhidrosis, salivation, tearing, cyanosis, pulmonary edema, muscle twitches, convulsions, coma, areflexia, and loss of sphincteric control. Goose flesh appearance of the skin has been observed as a further aid in diagnosis. These changes are reversible with prompt and adequate therapy, and atropine is the therapeutic drug of choice.

Pyrimethamine in the Treatment of Polycythemia Vera. By John W. Frost, M.D., Ralph Jones, Jr., M.D., and Ulfar Jonsson, M.D. South. M. J. 51:1260-1265 (Oct.) 1958.

It is the purpose of this paper to present the results of studies which demonstrate that pyrimethamine (2,4-diamino-5-P-chlorophenyl-6-ethylpyrimidine), (Daraprim) has clinically useful therapeutic activity in patients with polycythemia vera, that the therapeutic effects of this compound are due to competitive interference with folic acid metabolism, and that it can reproduce all the features of folic acid deficiency in humans. Fourteen patients with polycythemia vera, treated from three to 26 months, received a total of 17 courses of pyrimethamine to control the disease. In 11 of the patients there was a fall in hemoglobin, hematocrit, and red blood cell counts. Side effects in several patients consisted of thrombocytopenia, leukopenia, atrophic glossitis, ulcers of buccal mucous membranes, alopecia and megaloblastic bone marrow changes. Never serious, these side effects could be reversed by folic acid even with continued pyrimethamine administration. The authors stated that the reversal of all demonstrable biologic effects of pyrimethamine by concurrent administration of folic acid indicates that its therapeutic effects in polycythemia are entirely due to its function as a folic acid antagonist. They concluded that, in spite of some disadvantages, the drug can be used to control polycythemia satisfactorily in most cases.

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 2411, Jacksonville, for abstracting and publication in The Journal. If you have no extra reprints, please lend us your copy of the journal containing the article.

PRESIDENT'S PAGE

Resolutions For 1960

WHEREAS it has been customary for many generations for individuals and groups of individuals of serious thought and sincere purpose such as the Florida Medical Association to make Resolutions at this time of year, and

WHEREAS such Resolutions are made for the purpose of improving the efforts, or morals, or attitude of the individual or group making such, and

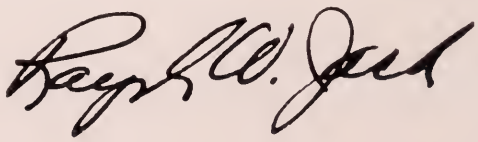
WHEREAS the physicians of America are interested in the welfare and reputation of physicians everywhere, and are especially eager that the accomplishments of the Medical Profession continue to become progressively greater, now

THEREFORE, BE IT RESOLVED that we live up to the heritage we have received from our forefathers in Medicine and continue to earn and deserve the privileges and esteem awarded to our profession by a grateful public as we keep our ideals, ethics, and scientific knowledge on a most high plane, and

FURTHER, BE IT RESOLVED that we be good citizens as well as good physicians and assume our other responsibility as leaders in all phases of our community life, including politics, and

FURTHER, BE IT RESOLVED that we work as diligently and as constantly as our adversaries to do everything we can to preserve the freedom of our profession and also the freedom of all men.

Respectfully submitted,



And A HAPPY NEW YEAR to all of you.

THE JOURNAL
OF THE
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To Care For One's Own

Only a few years ago the newspapers, radio and television were filled with the details about a little boy who fell into a pit near his home and was almost suffocated. Through the tireless efforts of rescuers, working night and day, the child was saved. From the earliest moments of the emergency, a local physician remained at the site of the catastrophe giving advice and supervising the administration of oxygen and other items which proved effectual in saving the boy's life. When the child again took a breath of fresh air from the surface of the earth, the whole populace breathed a sigh of relief with him and neighbors felt a bit closer to know that in times of dire distress even strangers would band together to save a child's life. We had taken care of our own. But the air of exultant joy was soon pervaded by a stench that remained in men's nostrils for months. The miasma was so overwhelming that it is doubtful if the physician who worked so faithfully and tirelessly in the rescue operations will ever be the same.

What history lacks in colorful emotional overtones it makes up for in succinct immutable satisfying facts. The physician sent the parents a bill for his services rendered to the child. Superficially the bill was large for the average working family. Yet this family was no longer average. Television appearances had contributed sizable cash sums to the parents' assets.

With the aid of a *good press*, however, the parents and child were made to appear the victims of an overcharging, heartless charlatan. Offers came from far and wide to pay the physician for his pound of flesh. He was denounced by radio and TV commentators, and the weekly news magazines not only took joy in crucifying him with biased reports, but also printed almost to exclusion only letters condemning a physician for doing what was his moral, legal and ethical right —charge a fee which he believed was right.

From a hero the physician now became a Shylock. None would carry his standard. Finally, his own American Medical Association, speaking from the mouth of one of its official physicians, made an utterance to the effect that the average physician would not have done as this damned one had. The physician withdrew his bill. The

parents were happy. They had more money in the bank than ever. Their lawn, which had been trampled upon by those aiding, as well as those watching, could be replaced and the landscapers paid. Other incidentals, such as thanks and humility, were really unimportant anyway.

If is useless, if not neurotic, continually to bemoan ill fortune that has past. To be a flagellant accomplishes nothing except the gratification of some masochistic tendency. If, however, by reminding ourselves of some unfortunate event we can learn to profit, then let us open up the old wound so that our memories are refreshed and never again wittingly err similarly.

To care for one's own is a credo based on survival. Various groups band together for their own protection, but in these days of supposed civilization they really join for their own betterment. Such an organization is the American Medical Association. It is therefore most distressing to recall that when a physician was beset with troubles and criticisms enough to have crushed a lesser man, some official of the American Medical Association whose name it is hoped is well forgotten added the final blow of condemnation. Had there been time for investigation, had there been time to let rancor quiet, had there been time to let the emotional caldron cool before making a quasi official decision, then even a complete denunciation of the physician by the American Medical Association would have been acceptable.

It is well to remember. It is well to atone. Changes have occurred recently in the hierarchy and bureaucracy of the American Medical Association which should prevent a recurrence of similar unfounded condemnations. We expect news magazines to color and slant news as their editors desire. Even these media recanted their early condemnations by admitting that by far the majority of people who had written them thought the succoring physician was right and just in his charge. Of course, when these facts were made known, everyone had lost interest. The only one who cared was the now almost forgotten physician. And why remember him? It is well to remember and well to atone if we wish to protect ourselves from the punishment inflicted on one of our own for whom we did not care. To care for one's own is a credo. It must never be forgotten if the organization of physicians into groups for their own benefit is to have any meaning.

J.J.L.

Biochemical Genetic Defects

The influence of genetic makeup on the occurrence of human disease, and mental disorders in particular, has up until recently been limited to the description of a few rare metabolic errors of metabolism. As the details of intermediary metabolism in these conditions have become better known, the understanding of human disease on a molecular and enzymatic level has progressed. Phenylketonuria, galactosemia, the glycogen storage diseases, and the nonendemic types of cretinism are a few well known examples of the rapidly expanding list of such altered heritable metabolic abnormalities that have contributed much to medical knowledge.

Advances in the fields of biochemistry and genetics are now providing newer methods for the study of such abnormalities of metabolism. Unfortunately, for a variety of reasons, clinical investigators and research workers interested in human disease associated with physical and mental retardation have been hampered in their work and deprived of access to clinical case material. The limited number of cases, geographic isolation, dependence on fairly elaborate research equipment and facilities, and a general apathy on the part of physicians along with society in dealing with such patients constitute some of the major causes for this state of affairs.

Traditionally, state training schools and institutions for the mentally retarded have been sequestered into the countryside, remote from society, medical consultation and access to research facilities. Society's apathy and "out of sight, out of mind" attitude have brought about this geographic isolation to a degree that, with the exception of the state of Florida, there is no

state-supported institution for the care of the mentally retarded within a radius of 40 miles from a university medical teaching center.

Of all the states, Florida has the only large university hospital and medical school geographically situated within five miles of a state training school for the mentally retarded. The medical center is still in its early development, but already advances are being made in applying current biochemical techniques to the study of mental retardation and hereditary diseases. Extensive study of the connective tissue acid mucopolysaccharides as they occur in urine and tissues in the Hurler syndrome (gargoylism, lipochondrodystrophy, dysostosis multiplex), a grotesquely deforming, heritable disorder of connective tissues, is in progress. While these studies have already aided in the early diagnosis of this condition, they also carry the promise of casting light on the basic defect in this experiment of nature, which can transform an apparently normal infant into a hideous, mindless imbecile in a period of a few short years.

The studying of the Hurler syndrome in which there is a storage or accumulation of abnormal amounts of naturally occurring acid mucopolysaccharides in nearly all tissues of the body, and excessive excretion of these substances in urine, may in turn add to the understanding of the role of connective tissue acid mucopolysaccharides in physiologic and pathologic processes. The pathogenesis of the delayed skeletal maturation, the premature changes in the coronary and large blood vessels that resemble arteriosclerosis, the nodular thickening of the mitral and aortic valves, the progressive mental deterioration, the flexion contractures of the extremities, and the hirsutism found in this disorder are but a few of the unanswered problems posed by this metabolic anomaly.

Fortunately, the proper milieu for the extension of these and similar studies in allied metabolic disorders now exists in Florida. The persons with problems of retarded physical and mental growth will no longer be isolated from adequate medical consultation, and clinical investigators will more readily be given the opportunity to uncover the basic etiology of such disorders.

Andrew E. Lorincz, M.D.
Assistant Professor
Department of Pediatrics
College of Medicine
University of Florida

Cardiovascular Diseases Seminar Jacksonville, Feb. 18-20, 1960

The Seventh Annual Seminar on Cardiovascular Diseases has been scheduled for Thursday, Friday and Saturday, February 18-20, at the Prudential Auditorium in Jacksonville. The Seminar is sponsored by the Northeast Florida Heart Association in cooperation with the Division of Postgraduate Education of the College of Medicine of the University of Florida, and the course is accepted for credit by the American Academy of General Practice. Dr. Daniel R. Usdin of Jacksonville is president of the Northeast Florida Heart Association. Dr. Max Michael Jr., Executive Director of the Jacksonville Hospitals Educational Program, is in charge of the program.

The speakers for the Seminar include Dr. James V. Warren, Professor and Chairman of the Department of Medicine, University of Texas Medical College, Galveston; Dr. H. S. Weens, Professor and Chairman of the Department of Radiology, Emory University School of Medicine, Atlanta; Dr. Jesse Edwards, Professor of Pathology, Mayo Clinic Foundation, Rochester, Minn.; Dr. Proctor Harvey, Georgetown University School of Medicine, Washington, D. C., Dr. Richard P. Schmidt, Associate Professor of Medicine, College of Medicine, University of Florida, Gainesville, and Dr. Frank Spencer, Associate Professor of Surgery, Johns Hopkins Hospital, Baltimore.

Dr. Michael stated that the program of the Seminar would be similar to that presented last year with the formal presentations correlated with panel discussions and question periods during which the entire staff will participate. The lecturers primarily will discuss the cardiovascular diseases, their diagnosis and treatment.

New Telephone Number J. Hillis Miller Health Center University of Florida

Beginning Jan. 17, 1960, the telephone number of the J. Hillis Miller Health Center at the University of Florida again will be changed. The new number will be FRanklin 6-3211.

The Southern Bell Telephone and Telegraph Co. has explained that the change in the number was necessary to insure adequate telephone service in the future. This makes the second time the number has been changed since the Teaching Hospital and Clinics opened in 1958.

PROGRAM OUTLINE - 1960 ANNUAL MEETING
FLORIDA MEDICAL ASSOCIATION

	Friday April 8	Saturday April 9	Sunday April 10	Monday April 11
MORNING	Registration 8:30 Visit exhibits	First Scientific Assembly 9:15 Address 9:35 " 9:55 " 10:15 " Recess to visit exhibits Reference Committee Meetings	Specialty Groups	Third Scientific Assembly 9:15 Address 9:35 " 9:55 " 10:15 " Recess to visit exhibits
		Panel: "Recent Developments in the Treatment of Infections" 11:00-12:00		Panel: "Management of Acute Trauma" 11:00-12:00
AFTERNOON	House of Delegates First Session 1:30 Delegates' Registration 2:00 House in Session	General Session 1:30-2:30 Recess to visit exhibits		House of Delegates Second Session 1:30 Delegates' Registration 2:00 House in Session
	Annual Meeting, Blue Shield	Second Scientific Assembly 3:00 Address 3:25 " 3:50 " 4:15 " 4:40 " 5:05 "		Board of Governors' Meeting
EVENING				

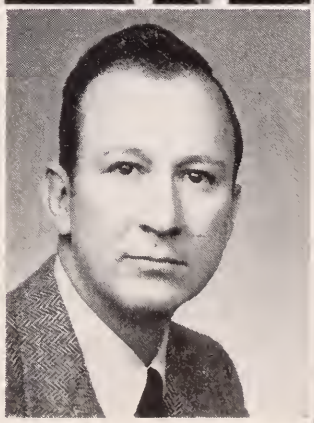
Guest Speakers For Annual Meeting

Dr. J. Graham Smith Jr. of Miami, (left) Assistant Professor of Dermatology, University of Miami School of Medicine. Guest of Florida Society of Dermatology. Title of address: "Griseofulvin in the Treatment of Fungous Infections."

Dr. Richard T. Smith of Gainesville, Professor and Head, Department of Pediatrics, College of Medicine, University of Florida. Guest of Florida Pediatric Society. Title of address: "Treatment of Respiratory Infections in Children."

Dr. John L. Bell of Chicago, (left) Assistant Professor of Surgery, Northwestern University Medical School. Guest of Florida Chapter, American College of Surgeons. Title of address: "Management of Acute Trauma of the Hand."

Dr. Paul C. Bucy of Chicago, Professor of Surgery, Northwestern University Medical School. Guest of Florida Neurosurgical Society. Title of address: "The Treatment of Craniocerebral Injuries."



Dr. Crawford J. Campbell of Albany, N. Y., (left) Chief of Orthopaedic Surgery, Albany Hospital: Associate Professor at Albany Medical College. Guest of Florida Orthopedic Society. Title of address: "Problems Peculiar to the Management of Acute Traumata in the Bones of Children."

Dr. John M. Converse of New York, Lawrence D. Bell Professor of Plastic Surgery, New York University College of Medicine. Guest of Florida Society of Plastic and Reconstructive Surgery. Title of address: "Blow-Out Fracture of the Floor of the Orbit."

Dr. John J. Procknow of Chicago, Assistant Professor of Medicine, School of Medicine, University of Chicago. Guest of Florida Chapter, American College of Chest Physicians. Title of address: "Fungous Diseases of the Lungs."

Dr. E. L. Foltz of Philadelphia, Staff Member of the Pepper Laboratory of Clinical Medicine, University of Pennsylvania School of Medicine. Guest of Florida Academy of General Practice. Title of address: "The Role of Antibiotics in the Management of Infectious Diseases." (Photograph not available at press time.)

Second Annual Conference County Medical Society Presidents and Secretaries January 16 and 17, 1960

The incoming presidents and secretaries of Florida's county medical societies will gather in Jacksonville this month for the Second Annual Conference for County Medical Society Presidents and Secretaries, sponsored by the Florida Medical Association. The meeting will be held in Jacksonville at the Hotel Robert Meyer, beginning on Saturday, January 16, at 2 p.m. and continuing until noon on Sunday. The initial conference last year proved the value of such a gathering to the new officers of the Association's component societies and evoked sufficient interest to insure a large attendance this year.

The program has been arranged to cover current programs, plans and problems at the national, state and county levels. A special feature this year is the period set aside on Sunday morning for the county medical society officers to discuss their mutual programs and problems. The program follows:

SATURDAY, JANUARY 16, AFTERNOON SESSION

Ralph W. Jack, M.D., President, Florida Medical Association, Presiding

1:45 p.m.	Registration	
2:00 p.m.	Welcome to Assembly (Purpose of Meeting)	Ralph W. Jack, M.D.
2:15 p.m.	Current Policies and Programs of the American Medical Association	Ernest B. Howard, M.D.
2:45 p.m.	Responsibilities of the County Medical Societies	Jere W. Annis, M.D.
3:00 p.m.	New Florida Medical Association Charter and By-Laws	Samuel M. Day, M.D.
3:15 p.m.	Forand Type Legislation and Aging	H. Phillip Hampton, M.D.
3:45 p.m.	Florida Medical Foundation	John D. Milton, M.D.
4:00 p.m.	Florida Medical Association Investment Trust	Floyd K. Hurt, M.D.
4:15 p.m.	Questions and Answers	
6:00 p.m.	Reception and Dinner	

SUNDAY, JANUARY 17, MORNING SESSION

Leo M. Wachtel, M.D., President-Elect, Florida Medical Association, Presiding

9:00 a.m. to 12:00 noon	The morning session will be devoted to county medical society officers for discussion of their mutual programs and problems. (Time for this type of discussion was requested by many of those who attended the conference last year).

Early 1960 Bahamas Conferences

During the first four months of this year, Bahamas Conferences offers four conferences of interest to Florida physicians. All are scheduled for Nassau in the neighboring Bahamas. The registration fee for each conference is $75, and registrants will receive an official certificate of attendance for deduction purposes. For American citizens passports are not required, and vaccination certificates are not now required. There are direct flights to Nassau from Miami and Fort Lauderdale and boats from Miami.

The Second Bahamas Surgical Conference will be held from December 28, 1959, through January 16, 1960, and the Second Bahamas Serendipity Conference from January 17 until January 30, 1960, both at Nassau's British Colonial Hotel. From March 5 until March 12, 1960, the First Bahamas Allergy Conference will take place at Nassau Beach Lodge. Beginning on April 1 and continuing until April 14, 1960, the Ninth Bahamas Medical Conference will be held at the British Colonial Hotel. Further information may be obtained by contacting Dr. B. L. Frank, Organizing Physician, Bahamas Conferences, P. O. Box 4037, Fort Lauderdale.

President Jack Sounds an Alert

With the convening of the Congress this month for its 1960 session, excerpts from an address made by Dr. Ralph W. Jack, President of the Florida Medical Association, to the Woman's Auxiliary to the Florida Medical Association at its annual meeting in Tallahassee last fall are particularly timely. Dr. Jack assigned the doctors' wives the role of "an additional weapon," one definition of the word "auxiliary," in the battle physicians are now waging against a cancer of society that can be just as deadly to human beings as any other cancer known unless it is detected early and eradicated. "Socialism," he asserted, "—socialistic invasion of your free enterprise system—will bring certain death to society. Our Nation has lost several good friends among nations to this type of cancer. The disease is attacking our Nation and we must be alert and stamp out its early beginnings if we are to save our society from a cancer death of this kind. The most recent evidence of this disease has shown up as a new approach to socialized medicine: a Bill being presented to the 86th Congress of the United States, H.R. 4700, better known as the Forand Bill.

"There is no doubt but that those who wish to socialize this country will make a big push to pass this legislation when Congress reconvenes in January 1960. This Bill is a new method to spread the cancer of society—Socialism; a new side-door approach to 'socialized medicine.' It is more dangerous than the Murray-Wagner-Dingell Bill although at first glance it does not appear as bad. The Murray-Wagner-Dingell Bill would have brought socialized medicine to the United States in one fell swoop. The Forand Bill is simply the down-payment that will deliver socialized medicine bit by bit on the installment plan.

"In brief, H.R. 4700 would again increase Social Security taxes and extend hospitalization, nursing-home care and surgical services to recipients of Social Security benefits. It is the fine print in this Bill the medical profession must bring out and analyze for the public. We are the experts in the field of health who must do that. Faced with a frontal attack like the Murray-Wagner-Dingell Bill offering a choice between socialized medicine and medicine practiced in freedom, the people of this country chose easily, quickly and unmistakably. If they are informed regarding the implications of the Forand Bill,

Dr. Jack

they will turn thumbs down on this piece of legislation, but if we do not accomplish this bit of public education, they may well be sold a bill of goods they don't need and at a price they can't afford."

Dr. Jack made a strong plea for "an informed public writing their congressmen and senators about their beliefs regarding this type of legislation." He urged the writing of thousands of letters to overcome the lead already taken by a minority group of loud, noise-making, socialistic politicians. "The public must be made to know that this Bill would not result in better but rather poorer health care for the people of this country. Since the beginning of the century, revolutionary advances in medicine and improved medical and public health progress under a free enterprise system have increased the life expectancy of the average American by 20.5 years. More people live more years and all people live healthier lives."

To accomplish the objective of getting the public well informed, the physicians of Florida as well as their wives may well heed the five suggestions Dr. Jack made to the members of the Auxiliary. They were:

"1. Each of us must become a missionary within our own circle of acquaintances and explain to our patients and friends the dangers of political medicine. We need allies. If we spell out the facts, we'll get them because the truth is on our side.

"2. We must be prepared to write letters ourselves and encourage others to write to their own congressmen, setting forth the reasons why the Forand Bill is bad medicine for the Nation.

"3. Let us seek the support of nonmedical

groups which share our principles and oppose needless government intervention.

"4. Let us use the materials available to us through the A.M.A. on the subject of Forand legislation and distribute them as widely as possible to patients, friends and neighbors.

"5. Let us remind the people of Florida about the tremendous advances in the care of the aged already accomplished in our State. These are well-outlined in the testimony given before the House Ways and Means Committee by Dr. H. Phillip Hampton of Tampa, Chairman of the F.M.A. Committee on Legislation and Public Policy."

This testimony was published in the October 1959 issue of The Journal.

Dr. Jack, in conclusion, urged the doctors and their assistants not to allow this cancer of society to spread by apathy and default. "We must assume our rightful role as intelligent, educated leaders in the community," he said. "We must take an interest in politics before politics takes us."

Florida Physicians Testify Before Senate Sub-Committee On Problems of Aged and Aging

The United States Senate Sub-Committee on Problems of the Aged and the Aging, at its Miami hearing on Dec. 2, 1959, heard the testimony of Florida physicians officially representing several organizations. These physicians and the organizations they represented were: Dr. Edward R. Annis, of Miami, the Governor's Citizens Medical Committee on Health; Dr. Jere W. Annis, of Lakeland, Blue Shield—Blue Cross; Dr. Charles K. Donegan, of St. Petersburg, the Florida Society of Internal Medicine; Dr. Samuel Gertman, of Miami, the Committee on Health of the Welfare Planning Council of Dade County; Dr. H. Phillip Hampton, of Tampa, the Florida Medical Association; and Dr. Wilson T. Sowder, of Jacksonville, the Florida State Board of Health.

Dr. Hampton, Chairman of the Association's Committee on Legislation and Public Policy, presented the following testimony:

STATEMENT OF
THE FLORIDA MEDICAL ASSOCIATION
United States Senate
Sub-Committee on Problems of
the Aged and Aging
Miami Hearing
December 2, 1959

Mr. Chairman and Members of the Committee:

I am Dr. H. Phillip Hampton of Tampa, Florida where I am engaged in the private practice of medicine. I am a Member of the Board of Governors and Chairman of the Legislative and Public Policy Committee of the Florida Medical Association.

In 1954 the medical doctors of Florida requested the Governor to appoint a committee to study the problems of medical and hospital care in this state with particular reference to those who were unable to provide this care for themselves.

A major finding of the committee pointed out that there are two groups of individuals unable to pay for medical and hospital care: (a) those persons on the state welfare rolls who require public assistance for food, clothing and shelter and (b) those persons who, after proper investigation, are found able to provide the basic necessities for themselves but cannot meet the cost of major medical care and hospitalization—the medically indigent.

The committee recognized that indigency was a disease with economic, sociologic, medical and political causes which needed to be eradicated by specific treatment in order to rehabilitate the individual to independence. A merely supportive approach to the problems of indigence leads to an incurably chronic condition of indigence as a way of life with the individual completely dependent upon the state and free of responsibility.

The committee recommended establishment of a uniform system of hospitalizing the acutely ill indigent by creation of a state and county matching fund out of which payments might be made directly to hospitals for the costs of caring for certified indigent; the smaller government (county) units would be encouraged to assume the major administrative and financial responsibility. Plans for care of the chronically ill and outpatient care of indigent were to be made after additional study. It was assumed the doctors of Florida would continue their services to the acutely ill, hospitalized indigent persons without charge, pending further study.

The recommendations were enacted into law by the Florida Legislature and became effective 1 January 1956. The program is administered through the county health officers and is flexible enough to meet the individual problems of each county. The health officer may delegate determination of indigence and other duties to qualified

agencies. A one-page form is used by the physician, who makes the diagnosis and refers the patient for hospital admission, by the social worker who determines indigence, and by the hospital for the bill.

Sixty-four of Florida's sixty-seven counties (97% of the population) voluntarily joined the statewide program to provide hospital care for the acutely ill indigent and the plan has functioned to the satisfaction of patients, hospitals and physicians. No Florida citizen is denied hospital care who needs it.

With a yearly expenditure of approximately $2,000,000 in state funds and $2,000,000 in county funds about 22,000 indigent are provided hospital care each year at an average hospital daily cost of $20 and average hospital stay of 9.6 days; 46% have been public assistance recipients and 54% medically indigent. Twenty-six per cent were aged 65 and over. In only 10% of the admissions was there participation in payment to the hospital by family, charitable organization, or insurance.

Continuing their study on the problems of medical care, the second Citizens Medical Committee on Health appointed by the Governor recently made the following pertinent recommendations:

1. For the extension of the benefits of health insurance: through every practicable channel encourage the development and promote the use of voluntary low cost health insurance which will extend benefits to the aged and cover long term illnesses.

2. For reduction in the costs of hospital care in long stay illnesses: the encouragement of the construction and operation of "limited service hospitals" in close proximity to major general hospitals to promote early transfer of patients from general hospitals and to provide efficient long term care of chronic diseases.

3. For more adequate nursing home care: legislative authorization for the Welfare Board to implement a program to pay the cost of nursing home care for public assistance recipients, this to be provided by county, state and federal matching funds; also encouragement of the active participation of religious groups in developing and maintaining nursing home facilities.

4. For accessible and economical medical care for the aged and those with chronic illnesses: the expansion of present outpatient clinics and the organization of additional clinics to meet the medical needs of the indigent and the chronically ill, with such services coordinated with and fully utilized in expanding and strengthening the intern and resident medical training program.

5. For home care of the aged and the chronically ill: within the realm of existing health agencies expand and modify community nursing programs so that the services of visiting nurses will be widely available and existing welfare agencies to sponsor foster home care, and homemaker and friendly visitor services.

6. For the provision of medical services to recipients of public welfare: the assignment of responsibility for medical and health matters to the medically-directed health agency with the evolution of appropriate inter-agency administrative relationships.

7. For increased state and local responsibility for medical care of the indigent program: use every possible influence to obtain a release to the states of tax sources now utilized by the federal government for the support of health services with planning and administrative responsibility centered as close as practicable to those served.

In accordance with these recommendations, the Florida Legislature this year amended the Hospital Service for the Indigent Law to include outpatient medical care and development of ancillary medical and nursing out-patient services and implementation is proceeding as rapidly as available funds permit.

The Florida Medical Association has created the Florida Medical Foundation for the purpose of providing medical services for care of the indigent, postgraduate medical education and research. This organization can work closely with the State Board of Health and State Welfare Department in providing and coordinating these medical services.

The fabulous advances made in the field of hospital and medical insurance in recent years attest the responsibility the people of this country feel to individually provide medical care for themselves. In 1958, a survey revealed that 63% of the population have health insurance, but only 35% of those aged 65 and over were insured. Led by Blue Shield and Blue Cross, insurance companies in Florida are improving their insurance coverage and are offering medical and hospital insurance on an individual basis to the aged. This is the American way.

In Florida, no one who needs it goes without hospital care. Voluntary health insurance is being

rapidly expanded and is the answer for the majority. Health needs of the indigent are provided for by medically directed statewide programs.

Only the practicing medical doctor can prevent the abuses necessary to insure the economical and effective operation of these medical insurance and indigent care programs. The initiative of the medical profession must be encouraged to assume the responsibility of these efforts, but it would be thwarted by government programs which assume individual responsibility of the physician and patient.

Florida is well on the way to finding answers to the economic problems of modern medical care through novel applications of traditional principles of individual responsibility in a cooperative manner.

We do not need additional federal legislation to solve these problems but we do need a relaxation of the rigid regulations directing health activities under federal welfare control and we do need release of certain federal taxes collected in our state so that these funds might be applied to solving our particular health problems in our way.

There are problems of the aged other than medical and hospital care which are of concern in their health and happiness. Such problems are boredom, continuing opportunity for employment and nursing home care.

If a problem in the economy and distribution of medical and hospital care exists in this country, can it not be solved by application of American ingenuity with the incentive and under the proven principles which have been our strength and not resort to questionably effective plans as tried by other governments foreign to our way and destructive to our traditional principles?

Florida Participants in 1959 Southern Medical Association Program

At the Fifty-Third Annual Meeting of the Southern Medical Association, held in Atlanta on Nov. 16-19, 1959, 17 papers on the scientific program were presented by Florida physicians, and 14 physicians from Florida discussed papers. In addition, Dr. Louis M. Orr, of Orlando, President of the American Medical Association, was the distinguished guest of Dr. Milford O. Rouse, of Dallas, President of the Southern Medical Association, and delivered an address at the President's luncheon.

Participants in the scientific program who presented papers and their subjects were: Dr. John B. Miale, of Miami, "Clinical Laboratory Studies in Connective Tissue Disorders;" Dr. Raymond E. Parks, of Miami, "Abdominal Distention: Ileus or Obstruction?"; Dr. John T. Stage, of Jacksonville, "Florida and Blue Shield Come of Age;" Dr. Hugh B. Goodwin Jr., of Fort Pierce, "Routine Stool Examinations in General Practice;" Drs. J. Allen Offen, Harold Schulman and James Henry Ferguson, of Miami, "Indications, Limitations and Technics of Conization of the Cervix;" Dr. Paul W. Boyles, of Miami, "Hemorrhagic Diathesis Associated With Long Term Anticoagulant Therapy;" Drs. Abraham R. Hollender and Jerome Benson, of Miami Beach, "The Lymphoid Tissue of the Nasopharynx: Factors Responsible for Certain Histopathologic Alterations;" Dr. Sherman B. Forbes, of Tampa, "Acute Glaucoma Following Extraocular Surgery Despite Definitive Ocular Preventive Measures;" Dr. Richard T. Farrior, of Tampa, "Cancer of the Mouth and Throat;" Dr. Arthur H. Weiland, of Coral Gables, "Lest We Forget;" Dr. William S. Hatt, of Sarasota, "A Simplified Method of Determining the Degree of Tibial Torsion;" Drs. Louis P. Brady and Eugene L. Jewett, of Orlando, "A New Treatment of Radio-Ulnar Synostosis;" Dr. Wallace E. Miller, of Miami, "Evaluation of the Colles Fracture;" Dr. Lee J. Cordrey, of Tampa, "Management of the Neuropathic Knee;" Dr. Richard T. Smith, of Gainesville, "Immunity in Early Infancy;" Dr. Benjamin L. Brock, of Orlando, "Comparative Results in Use of Two Commercial PPD Skin Tests in 572 Consecutive Admissions;" and Drs. Mark W. Wolcott, Oswald H. Coury and George L. Baum, of Coral Gables, "Changing Concepts in Therapy of Lung Abscess: A Twenty Year Survey."

Florida physicians discussing papers were: Drs. J. Gerard Converse, J. Graham Smith, Ralph Jones, Kenneth S. Whitmer, Claude G. Mentzer and Raymond E. Parks, of Miami; John R. Neefe, of St. Petersburg; Richard F. Sinnott, of Fort Pierce; Merton L. Ekwall and Sullivan G. Bedell, of Jacksonville; and Edward R. Woodward, Hugh M. Hill, Harriet E. Gillette and J. Maxey Dell Jr., of Gainesville.

FLORIDA MEDICAL ASSOCIATION ANNUAL MEETING, APRIL 8-11, HOTELS ROBERT MEYER AND GEORGE WASHINGTON, JACKSONVILLE.

Teaching Hospital and Clinics University of Florida Formally Dedicated

Senator Lister Hill (D. Ala.) told the audience on hand for the dedication of the University of Florida's new Teaching Hospital and Clinics that the J. Hillis Miller Health Center "has a magnificent opportunity to advance the studies of tropical medicine." In his dedicatory address, Senator Hill suggested that the University pool its research resources with other agencies in Florida and Central and South America to combat diseases which might spread to "epidemic proportions" and threaten the health of the entire hemisphere.

The new $9.6 million structure, although opened for the admission of patients a year ago, was formally dedicated in ceremonies on November 20 and 21, 1959. Dr. William Bosworth Castle, George Richards Minot Professor of Medicine at Harvard Medical School, was the guest lecturer on Friday evening for the scientific lecture with which the program began. Saturday morning was devoted to the dedication rites.

On hand to extend greetings from their respective organizations were Dr. Louis M. Orr, President of the American Medical Association, and Dr. Russell A. Nelson, President of the American Hospital Association.

The building was formally dedicated by J. J. Daniel, Chairman of the State Board of Control. It was accepted on behalf of the University of Florida by Dr. J. Wayne Reitz, President, and on behalf of the citizens of Florida by Secretary of State R. A. Gray.

Senator Hill said that the establishment of the Health Center will provide great advances for the people of Florida in the years to come. He predicted that the "magnificent hospital and health center" will play a "vital role in lifting the health standards, not only of the people in Florida and throughout our country, but, hopefully, in all parts of the world." The famed Alabama senator, who was co-author of the Hill-Burton Hospital Construction Act and the new Health for Peace Bill, said, "Careful planning and remarkable foresight have characterized the development of the medical school and health center."

He cited the opportunity of the University to serve the South through the pioneering type of effort established by the Southern Regional Education Board, which has aided professional training for Southern youth throughout the area. He gave special praise to the late president of the University of Florida, Dr. J. Hillis Miller, who "devoted so much aim and thought to medical education."

The dedicatory prayer was pronounced by the late Dr. Miller's son, the Reverend William Hopkins Miller, pastor of Westminster Presbyterian Church in Fort Lauderdale.

Health Center officials are planning the publication of Senator Hill's address which may be obtained by writing the Publications Office J. Hillis Miller Health Center, Gainesville.

Attending the dedication ceremonies Saturday morning, November 21, are (left to right) Dr. Russell A. Nelson, President of the American Hospital Association; Dr. Louis M. Orr, President of the American Medical Association; Senator Hill; the Reverend William Hopkins Miller, pastor of Westminster Presbyterian Church, Fort Lauderdale, and Dr. George T. Harrell, Dean, College of Medicine, University of Florida.

Relieving Tension Under Pressure

In one month alone (June) of this year over eight million people bought about 350 million pills to relieve tension and anxiety and, for your information, spent some 20 million dollars. As one preacher complained, "The American people are so tense these days even my sermons don't put them to sleep." This, however, is but a small part of the picture for in this day of polyetiologic medicine stress is without a doubt the most frequently repeated factor in the etiology of dis-ease.

You can start anywhere you like—from the head with alopecia or balding to the feet with trichophytosis or fungus, from the skin with neurogenic dermatitis in to the intestine with colitis, from the brain throughout every organ and system of organs in the body—and you will find all are highly vulnerable to stress.

Daily we hear expressions, referred to as jargon but in reality quite meaningful, such as "he almost blew his top," signifying a cerebral hemorrhage, or the admonishment not to "get your bowels in an uproar," meaning colitis, or the expression "he almost busted a gut," for perforation of an ulcer.

Salter in "Conditioned Reflex Therapy" would have us believe that ulcers are due in large part to "bottling up" of our own venom and allowing it to gnaw on our stomachs rather than spewing it out on our antagonists, and in part this explanation is probably true. Certainly any doctor has seen cases of acute ulcer brought on by hate, fear, worry, or if you will, tension.

Perhaps this would not be true if the behavioral sciences had kept pace with this age. In the meantime we have to content ourselves with theories on conditioning, frustration-aggression and psychosomatic interrelations that somehow do not help us much and perhaps are not much better than the sedatives and tranquilizers.

The story has been told, or perhaps I should say has been told too often, of a patient whose chief complaint was bed wetting. His doctor, after due course (history, physical examination, laboratory work, et cetera), decided it was caused by worry and tension; so he gave him Miltown, one of the most ballyhooed of the tranquilizers. Later, when he saw the patient and inquired about his health, he was told that the patient was fine now. He was pleased to hear this and asked how long it had been since the patient had wet the bed. "Oh," said the patient, "I still wet the bed, but since I started taking the medicine, I just don't care."

To approach the problem in a little different way, we might talk a little about environment. First, let us consider the internal environment and the jealousy with which it is guarded. Claude Bernard first conceived the idea of its constancy —for in the face of constant flux it is extraordinarily constant. This has been referred to as metabolic homeostasis by the physiologists, but might be better understood by you as physiological economy for it is the sum total of supply and demand in the body.

For the sake of simplicity we will consider only the blood sugar. The normal blood sugar is between 80 and 120 mg. per hundred cubic centimeters—let us call it 100. We awaken in the morning and our blood sugar is 100. We get up, bathe, shave, dress and perhaps take a little exercise and the blood sugar remains 100. We eat a hearty breakfast and in order to do so we may have to fight our way through a few plastic containers, but our blood sugar is 100. We drive to the office, work all morning and still our blood sugar remains 100. And so it goes throughout the day—provided the demands of the external environment are not too great. Now, here is where stress, the villain, enters to disrupt this steady state and we have dis-ease.

We have a disagreement with an associate or blowup in a conference; the adrenal glands are stimulated, to fight or flight as has been said, and up goes our blood pressure, up goes our blood sugar, and we are quick, energetic and stimulated as long as the demand exists or until we are just plain burned out. Then down goes the blood sugar and we are weak, wet and shaky. This is the same response, though a less healthy one, that the tennis player experiences after a game bounding in energy and lasting long enough to clear the net after the victory. Shortly thereafter he is spent and exhausted and to quench his thirst he raises a glass of water to his parched mouth only to find that his hand, only a moment before so

An address presented at the thirty-ninth annual meeting of the Associated Industries of Florida, Oct. 15, 1959, Jacksonville, by Dr. Matthew E. Morrow Jr., representing the Florida Medical Association.

steady, now shakes so violently that he can hardly find his face.

If such stress—and I am speaking mainly of the former type—is allowed to repeat itself constantly, the wear and tear will eventually show itself in dis-ease. Moreover, we must remember that there are many other elements of course involved in this hormonal rat race. The blood pressure, for instance, is stimulated each time and may remain alarmingly high, and the secretory phase of the stomach is enhanced and may lead to increased activity and acidity of that organ leading to ulcers or perhaps a spastic bowel.

The surgeon may help to change this internal environment by removing the adrenals or the thyroid or the pituitary or, for that matter, the worry portion of the brain, but this again is hardly a solution to our problem. What we must realize is that in most instances our overt responses are largely conditioned by the external environment. With the collapse of time and the tremendous daily change in our social and economic structure the stress of our external environment frequently becomes just too much for us.

Man is supposed to have been on this earth for at least 50,000 years, and there have been more developments in the last 50 years than in all the years before. What a simple life it must have been some 6,000 years ago for the Sumerian whose life was limited to a few acres on the banks of the Euphrates and who was quite content with his potato economy. Now, before we have settled our worldly problems, we are flying off to the poor old moon and conquering outer space.

Perhaps, however, there is some hope for a solution. Bertrand Russell, that brilliant philosopher, has pointed out that we have great need to expand our mental universe to balance the expanding physical one. What he means is that we must develop our willing and emotions in step with our thoughts. If we can learn to understand ourselves better, then perhaps decisions need not be dependent on the state of our stomachs nor conferences disrupted by fear of apoplexy.

In Dostoevski's "The Brothers Karamazov," I believe it is Alyosha who declares: "Everyone is really responsible to all men for all and everything." If we can keep our internal environment then in balance by understanding our external environment, we should be able to transcend the feelings of frustration and futility and tension that beset us at every turn in our present world. Perhaps the golden rule is still the best solution, and I believe that the golden rule will survive after all the other antiknowledge and gobbledygook have been discarded.

I do hope that I have not disappointed you too greatly this afternoon. This subject is so filled with clichés, such as "don't worry," "take up golf"—which, by the way, is a good example of frustration-aggression, or "get away from it all and go fishing," that it is difficult to avoid them. Furthermore, I have purposely avoided the four well known R's: Rest, Relaxation, Recreation and Religion, but this should, in no way, mean that I do not consider them highly important. I thought, however, that these might well come into play in your question and answer period.

I want to express my appreciation for being asked here this afternoon. I am honored to represent the Florida Medical Association at your meeting and I hope I have said nothing that will keep you from visiting your doctors regularly.

Matthew E. Morrow Jr., M.D.

Highlights of Mental Health Conference

The Annual Conference on Mental Health, sponsored by the Committee on Mental Health of the Florida Medical Association, was held at the Association's headquarters in Jacksonville early in November. Dr. William M. C. Wilhoit, Chairman of the Committee, explained in his opening remarks that it is customary for the Association to bring together at this time of year interested persons and representatives of the various agencies involved in the over-all mental picture in the state. Conferring as a group, reviewing the year's program and outlining plans for the new year in each of the respective areas represented lead to mutual exchange of ideas which can further consolidate and advance the accomplishments of each agency's program.

Reporting for the Florida State Board of Health, Dr. C. M. Sharp, Assistant State Health Officer, cited two major objectives, the establishment of child guidance clinics and the development of follow-up procedures for patients discharged from mental hospitals. He reviewed the recent results of the follow-up care of discharged tuberculosis patients and suggested this type of program for following up discharged mental patients. Also, he expressed the hope that the rapid advancement now being made in the tuberculosis

field would in the next few years make possible the conversion of another tuberculosis hospital to a mental hospital as is now being done in Orlando.

The major services of the State Board of Health and the efforts being made to bring mental health principles into each phase of public health work were outlined by Dr. Wayne Yeager, Director of the Bureau of Mental Health. He stated that 16 child guidance and outpatient psychiatric clinics are now affiliated with the Board, and all but two have increased their psychiatric time since the Florida Psychiatric Society set as a minimum standard for approval 20 hours per week of psychiatric time. The Board approved this standard and hoped to satisfy it this year. Of particular interest were the Board's efforts to develop a new professional group whose members do not need to have long years of university and postgraduate training to carry on their work of supplementing the various psychiatric services.

Dr. W. D. Rogers, Director of the Florida State Division of Mental Health, reported the present rate of patient separation equals the admissions, but added that the number of patient admissions will increase in proportion to the growth of the state's population. He estimated that many of the elderly patients coming into the hospitals and at least 20 per cent of the present patients could be cared for in a nursing home situation. Declaring that outpatient and home service programs should become more 'regionalized' in the future, Dr. Rogers favored for both of these programs involvement of only a 50 mile radius at each hospital and increase of none of the new hospitals to more than 2,000 patients. He explained the real need for the planned psychotic child service which is now held up because of lack of appropriation of funds. His report evoked a broad discussion of the increasing role of nursing homes.

Dr. John T. Benbow, Superintendent of the Northeast Florida Mental Hospital at Macclenny, reported a tremendous turnover at that hospital already. Most of the facilities are of the intensive treatment type without any chronic or geriatric wards. In reporting on the Southeast Florida State Mental Hospital, Dr. Arnold H. Eichert, Superintendent, mentioned in particular the problem of adequate staffing as each state tries to outbid the others for doctors' services.

The Sunland Training Center Clinical Director, Dr. C. H. Carter, reported that the establishment of the new facility in Orlando will help to create space for the 1,200 patients currently on the waiting list, but warned of even more new applications when the new facilities are opened. The plans at present are to move the infirmary and bed cases to Orlando and leave 550 beds available at Gainesville.

Dr. C. Brooks Henderson, Clinical Director, explained the twofold purpose of the Alcoholic Rehabilitation Program as (1) treatment and rehabilitation, and (2) education. He said the inpatient program had been stressed during the year and the daily census had been approximately 40. A needed follow-up service for discharged patients is getting under way, and facilities at Avon Park are to be expanded from 50 to 60 beds in order to balance out the male-female ratio. To solve the outstanding problem of alcoholics, often jailed, who are "not crooked enough for the Division of Corrections, not psychotic enough for the mental hospitals and not voluntary enough for Avon Park," he said a pilot program is now under consideration using a minimum professional assistance with Alcoholics Anonymous in a cottage type situation separate from the other facilities.

As president of the Florida Association for Mental Health, Dr. Wilhoit reported for that organization. During the year efforts were directed to strengthening the local chapters of the association and preparing them to take a more aggressive part in education for mental health. There are 26 county chapters in the state, two of which are now sponsoring a social club for discharged mental patients. Avoiding the therapeutic area, the association sponsors work shops at various times and places to promote the different phases of mental health, such as the 1959 Pre-School Orientation Work Shop, designed to help teachers recognize emotional problems in school children.

Dr. Peter F. Regan III, Professor and Head of the Department of Psychiatry of the College of Medicine of the University of Florida, who was the first staff member in May 1958, reported a present staff of five full time psychiatrists, 11 part time voluntary psychiatrists, a sociologist, a research psychologist, three clinical psychologists, a biochemist working on a research basis and the usual corps of research and clerical workers. Last year the University put into effect its full time teaching program, which gives each medical student a total of more than 500 hours of intensive

undergraduate courses in psychiatry. On the graduate level, the residency program began with the opening of the 40 bed inpatient service in July 1959, and the outpatient clinic has been functioning since January with an average of 70 patients.

The University of Miami School of Medicine now has five full time staff members on its psychiatric program, as reported by Dr. Henry L. Dean, Assistant Professor of Psychiatry. The program includes teaching resident students psychiatry and treating patients in the inpatient and outpatient clinics, and conducting research. As yet, however, the research program is not fully developed.

Speaking for the Council on Research and Training in Mental Health, Dr. Benbow reported that the majority of scholarships granted recently have been for psychiatric social work. All of the stipends are going to Jackson Memorial Hospital in Miami. He spoke of the difficulty of giving money away because the National Institutes of Health gives about 50 per cent more than the Council and with no restrictions. He also commented on the legislature's ruling that a recipient, instead of paying his grant by practicing in the state of Florida, may repay with money and not have to work with a state agency. In the field of research, he reported a cut in funds, stating that it is especially hard to find anyone who will engage in research.

Reporting for the Florida State Division of Correction, Mr. H. G. Cochran Jr., Director, stated that of the 6,300 inmates of the state's prisons, approximately 70 per cent will return to the prisons. He spoke of the role of liquor in crime and emphasized the need for help in trying to rehabilitate the men.

Dr. Earl N. Saunders of the Florida School for Boys at Marianna outlined the programs being developed at that institution. First among them is a general cottage program for the majority of the boys which in the initial stage has proved most successful. The school has a neuropsychiatric unit, and 51 boys have been treated on an inpatient basis, using a psychiatrist, a psychologist and ancillary workers. Future plans include a maximum security unit and an expanded social program to educate and work with the parents while the boys are in school and for follow-up after the boys leave. Of 165 runaways during the year, only eight were from the Negro section, probably because of stricter discipline and better living conditions than the home environment had provided.

Dr. Sullivan G. Bedell spoke briefly of a recent meeting of the liaison committee between the American Psychiatric Association and the American Academy of General Practice, held for the purpose of discussing the role of the general practitioner in the field of preventive mental health.

Representatives S. C. Smith and F. Charles Usina represented the Interim Legislative Committee on Mental Health at the Conference. As a member of this committee and as chairman of the committee of the Legislative Council that will be dealing with mental health and other state institutions during the next 16 months, Mr. Smith stated that the committee will be pleased to hear from the members of the mental health groups at any time. Mr. Usina, who is a state representative to the National Association for Mental Health, spoke briefly concerning certain local mental health problems in his county and requested assistance in determining their origin.

President Ralph W. Jack, of Miami, and President-Elect Leo M. Wachtel, of Jacksonville, represented the Florida Medical Association at the meeting. In addition to Dr. Wilhoit, of Pensacola, and Dr. Bedell, of Jacksonville, Dr. Zack Russ Jr., of Tampa, was present as a member of the Association's Committee on Mental Health. Mr. Robert Ferguson of the Clearwater Mental Health Association was also in attendance. It was the consensus of the Committee that the Conference was so successful and beneficial that it should be continued on an annual basis.

OTHERS ARE SAYING

Editorial

When I reflect on some of the things that were said at my graduation, the words "arts and science of the practice of medicine" comes back to me. To me, the "science of the practice of medicine" has been much easier to achieve than the "arts of the practice of medicine." I think this is probably true of all of us who have graduated in the past twenty years.

The advance of the science of medicine has been so rapid that it staggers ones imagination. Therapeutic avenues, both medical and surgical, have been opened and offer cures for conditions

wherever there is inflammation, swelling, pain

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Streptokinase-Streptodornase Lederle

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conditions for a fast & comfortable comeback

Host reaction to injury or local infection has a catabolic and an anabolic phase. The body responds with inflammation, swelling and pain. In time, the process is reversed. Varidase speeds up this normal process of recovery.

By activating fibrinolytic factors Varidase shortens the *undesirable phase,* limits necrotic changes due to inflammatory infiltration, and initiates the constructive phase to speed total remission. Medication and body defenses can readily penetrate to the affected site; local tissue is prepared for faster regrowth of cells. In infection, the fibrin wall is breached while the infection-limiting effect is retained. In acute cases, response is often dramatic. In chronic cases, Varidase Buccal Tablets can stimulate a successful response to primary therapy previously considered inadequate or failing.

for routine use in injury and infection ...new simple buccal route

Varidase Buccal Tablets should be retained in the buccal pouch until dissolved. For maximum absorption, patient should delay swallowing saliva.

Dosage: One tablet four times daily usually for five days. When infection is present, Varidase Buccal Tablets should be given in conjunction with Achromycin® V Tetracycline with Citric Acid.

Each Varidase Buccal Tablet contains: 10,000 Units Streptokinase and 2,500 Units Streptodornase.

Supplied: boxes of 24 and 100 tablets.

1. Innerfield, I.: Clinical report cited with permission
2. Clinical report cited with permission

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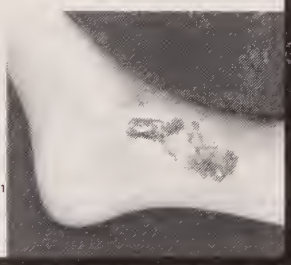
FORCE INJURY

severe bruises
. . . swelling
. . . cleared
by fifth day[2]



VARICOSE
ULCER

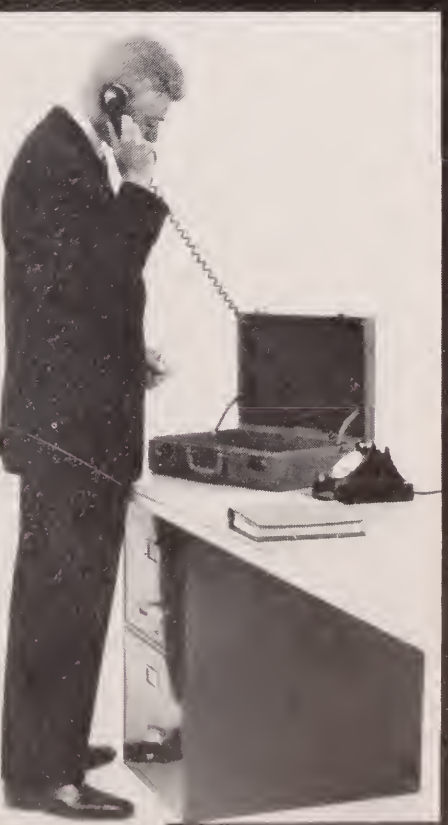
15 years duration
. . . resolved with
VARIDASE[1]

INFLAMMATORY
DERMATOSIS

rapidly spreading
rhus dermatitis
healed within
a week[1]

INFECTED
LACERATION

marked reversal
in 3 days . . .
returned
to school . . .
osure advanced[1]



THROMBOPHLEBITIS

back on his feet
in a week after
recurrent episode[1]

REFRACTORY
CELLULITIS

normal routine
resumed after 4 days
of VARIDASE[1]

of which there seemed no hope. I think that this progress will continue but I wonder how far we have progressed in the art of medicine.

Previously, there were so many missing links in the science of medicine that our fathers and older physicians had to depend a great deal on art. Now the situation is reversed and too many of us have either discarded the art of medicine or never attempted to cultivate it. Therein lies some of the problems that confront the physician today. Certainly the success cultists achieve are due primarily to their ability to sell themselves to the patient. It would be very gratifying if we could offer a complete and dramatic cure to every patient who visits us, but we are not able to do this. Sometimes the reason is that the condition is not remedial or, secondly, the patient may not be sick in a physical sense. These are the places that the art of medicine can be used to its best.

It is always quite discouraging to me to hear someone state that they or one of their loved ones have been given up by the medical profession and they have turned to some cult group for help. How much better it would be if this individual could say, "My doctor does not think much can be done but he is doing everything possible." Individuals with terminal cancer are some of the most discouraging people that we have to deal with, but they are in dire need of your help and reassurance. Sometimes an old-fashioned squeeze of the hand or smile is worth a lot more to the patient than a tranquilizer. Between closed circuit telecast, postgraduate courses and meetings it is easy to keep up on the science of medicine, but the art needs special care cultivation.

Richard L. Foster, M.D.
The Record
Broward County Medical Association
January, 1959.

Second Annual Conference
County Medical Society
Presidents and Secretaries
January 16-17, 1960
Hotel Robert Meyer
Jacksonville

BLUE SHIELD

You Have a Question, Doctor?

Questions, forever there are questions. This is nothing new. Curiosity is as old as man and is responsible for his remarkable progress in a relatively short period of time. He has come this far, not only by asking questions, but by repeating the same ones over and over until he is certain that he has the right answers. So it is with Blue Shield. The same questions keep reappearing, calling for new ways to give the same answers. Here are a few of those most often asked, with Blue Shield's attempt to find answers that will be clear to everyone.

Are Blue Shield and Blue Cross the Same?

No. Blue Shield is a plan sponsored by the medical profession which helps the subscriber pay for in-hospital and out-of-hospital professional services of doctors of medicine, and may pay the full bill if the subscriber is entitled to service benefits (in a low income group). It pays the doctor directly, if he is a participating physician. Blue Cross is a companion plan sponsored by hospitals which provides coverage for most in-hospital expenses, with variable allowances for room charges and other rather broad coverage for most hospital "extras."

Am I a Participating Physician?

You are if you are a Florida licensed doctor of medicine who has entered into an agreement to accept from Blue Shield as payment in full those covered professional services rendered to subscribers whose income falls within the limits specified in the subscriber's contract. If the subscriber's income exceeds these limits, the physician may charge the fee he deems appropriate, but the payment made by the Plan shall apply toward the total fee.

How Do I Know That a Patient Is Entitled To Service Benefits?

In the traditional physician-patient relationship, and at the time professional services are arranged for, you should determine whether the total annual income of the subscriber, including any income of all covered dependents, falls within the limits set by the type of contract held by the subscriber, shown on his identification card.

The Plan will enter this relationship upon request in case of dispute.

Will Blue Shield Pay More Than One Doctor On The Same Case When It Is Medically Necessary?

Under certain conditions. In most cases, Blue Shield will pay only the physician in charge for surgical, obstetrical or medical care rendered in any one hospital admission. When, however, two or more doctors treat separate and completely unrelated conditions covered under the contract during one hospital admission (concurrent or concomitant care), the Claims Committee, comprised of practicing physicians, will review information from the doctors involved and may authorize payment to more than one doctor.

Why Are Hospital Stays Primarily For Diagnostic Purposes Not Covered?

Primarily because the rate necessary to meet the additional claims would be higher than most subscribers would be willing to pay if diagnostic expenses were included among the benefits. Theoretically it is possible to write coverage for every conceivable expense in connection with an illness, but few people would be able to afford it.

Under What Conditions Are Blue Shield—Blue Cross Contracts Cancelled?

Only for fraud or failure to pay the required fees. No Blue Shield or Blue Cross contract in Florida has ever been cancelled because of age, health condition or utilization.

Why Must Doctors' Service Reports Be Filled in Completely and Promptly Submitted?

Primarily in order that the doctor may be paid without delay. If all required information is not included, it is frequently necessary to return the report to the doctor requesting the additional information, causing delay in payment, extra time and work for the doctor and additional administrative costs to the Plan.

Will Blue Shield - Blue Cross Provide "Major Medical" Type of Coverage Greater Than That Now Offered in the Basic Contract?

Yes. Beginning the first of the year groups with 15 or more employees will be offered an Extended Benefit or a Master Medical Endorsement to their basic Blue Shield—Blue Cross contracts which will provide greater coverage than they have been able to obtain previously. If the members of a group wish additional days' coverage and higher limits, but are not inclined to pay the higher cost of either endorsement, they will have the option of taking the Blue Shield "A" type contract.

Will Blue Shield-Blue Cross Offer Coverage To Government Employees Under the Recently Enacted Employees Health Benefits Act?

Until the final agreement is reached between representatives of Blue Shield—Blue Cross and the Federal Civil Service Commission, it is not certain whether the provisions will be acceptable to the Florida Plans. Final decision as to participation will be made by the Florida Medical Association's House of Delegates. We hope that Blue Shield will be able to participate, and every effort will be made to have the Doctors' Program available as a choice to federal employees.

Is Anything Being Done to Provide Coverage For the Aged?

Very definitely. (1) Blue Shield and Blue Cross have provided protection for subscribers 65 years of age and over for the last 14 years if they have been members of groups. (2) They and their eligible dependents 65 years of age have been permitted to retain membership on a direct pay basis when leaving groups regardless of age or health condition. (3) On Jan. 1, 1959 the age limit for nongroup applicants was removed, with acceptance dependent upon meeting the same underwriting conditions as other nongroup applicants. A special open enrollment of the aged for a short period, with underwriting requirements waived, is now under consideration.

Where Can I Get Additional Information on Blue Shield?

Consult any member of the Board of Directors, the Florida Medical Association's Committee of Seventeen or the Physician Relations Representative in your area, or write to Blue Shield at Jacksonville to the attention of Mr. H. A. Schroder, Executive Director. An informational bulletin called News Notes is mailed periodically to participating physicians.

We of Blue Shield hope that you will continue to ask questions for by so doing you let us know you are interested in your Blue Shield—and we believe that sustained interest will provide the basis for the future success of the Plan.

STATE NEWS ITEMS

Dr. J. Graham Smith Jr. of Miami reported on the effects of direct sunlight to the skin at the 12th annual meeting of the Gerontological Society held at Detroit the middle of November.

Dr. Leo M. Wachtel of Jacksonville, President-Elect of the Florida Medical Association, was one of the principal speakers at the annual meeting of the Florida Hospital Association held December 2-4 in Jacksonville.

Dr. Chas. J. Collins of Orlando was among the group of physicians from Florida who were in Atlanta the middle of November for the annual meeting of the Southern Medical Association.

Drs. James N. Patterson of Tampa and John A. Shively of Bradenton attended the meeting of the American Association of Blood Banks held in Chicago November 11-14.

Dr. Irwin S. Leinbach of St. Petersburg was one of the principal speakers at the annual convention of the Florida Society for Crippled Children held at Palm Beach the middle of November.

Dr. Thomas E. Langley of Eustis has been elected medical adviser to the Lake County Unit of the American Cancer Society for 1960.

Dr. Stanley E. Schwartz of Miami Beach has been elected president of the Greater Miami Chapter of Phi Delta Epsilon national medical fraternity. Other officers for the year include Dr. Seymour L. Alterman of Miami Beach, vice president; Dr. Morton L. Hammond of Miami, secretary, and Dr. Milton E. Lesser of Miami Beach, treasurer.

Dr. Leo M. Wachtel of Jacksonville, President-Elect of the Florida Medical Association, will be in Denver, Colo., January 10 for a meeting of the Denver Chapter of the American Academy of General Practice. He will participate in the Symposium on Medical and Surgical Problems of Old Folks sponsored by the University of Colorado and Lederle Laboratories.

Dr. Hawley H. Seiler of Tampa has been reelected secretary-treasurer of the Southern Thoracic Surgical Association which held its annual meeting the latter part of November in Biloxi, Miss.

Dr. James N. Patterson of Tampa was in New Orleans the last of November where he assisted in administration of examinations of the American Board of Pathology given at the Louisiana State University School of Medicine.

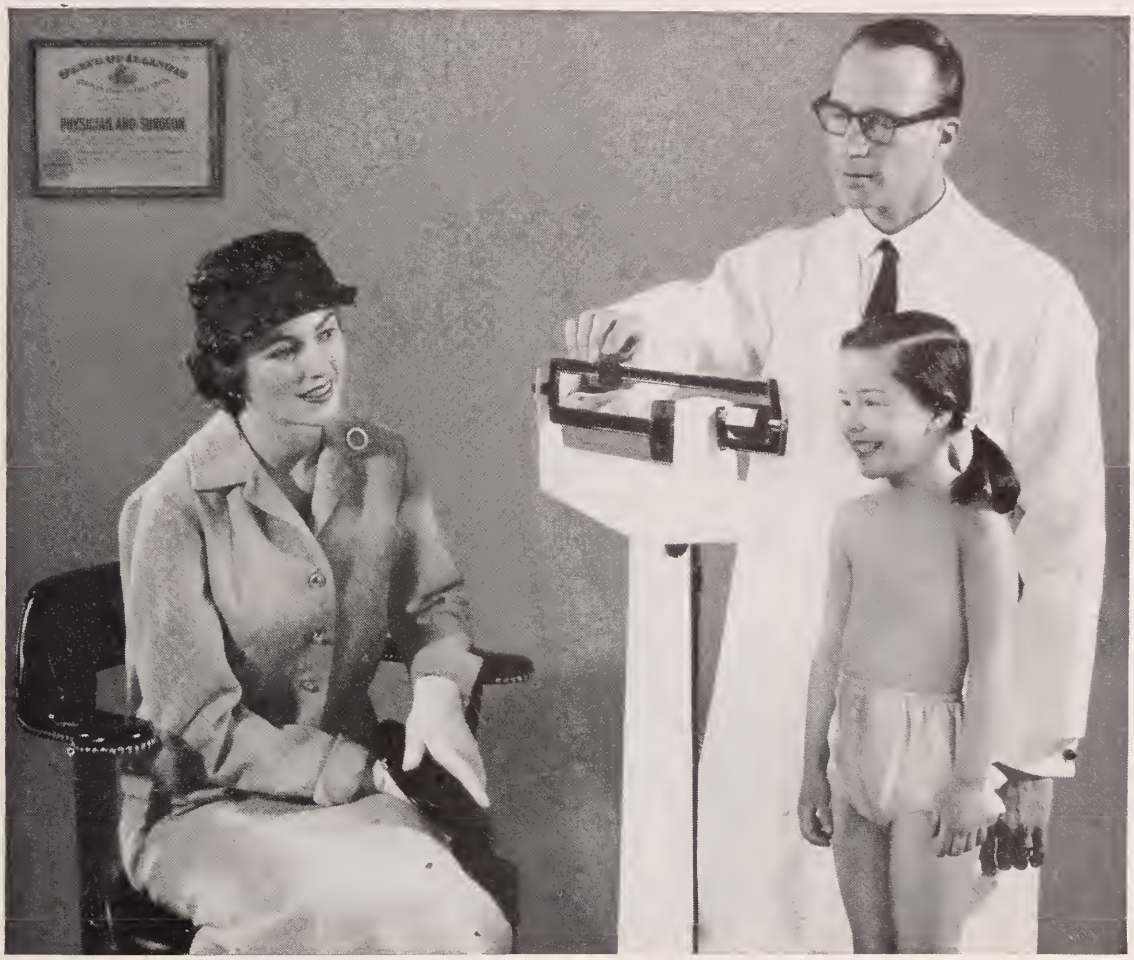
The 24th annual session of the International Medical Assembly of Southwest Texas is being held January 25-27 at the Hilton Hotel in San Antonio. Among the 17 speakers is Dr. John D. Reeves of Gainesville, Professor and Head of the Department of Radiology at the College of Medicine, University of Florida.

Dr. Lee E. Bransford Sr. of Jacksonville has been honored by the local Downtown Lions Club for his work in the sight conservation program. Dr. Bransford is one of the founders of the Club.

Drs. James N. Patterson and William W. Trice Jr. of Tampa and Dr. Malcolm B. Burris of Lakeland were among Florida physicians attending the meeting of the American Society of Hematology held recently at St. Louis.

Dr. Coy L. Lay of Lakeland has been elected chairman of the Lakeland Cancer Committee. Serving as committee chairmen will be Drs. John P. Collins and Samuel J. Clark, professional education; Dr. Edgar Watson, medical adviser and Dr. Frank H. Deland, cytology. All are from Lakeland.

The Seventh Panamerican Congress of Oto-Rhino-Laryngology and Bronchoesophagology is being held March 20-23 at Miami Beach in the Americana Hotel. Dr. Walter T. Hotchkiss of Miami Beach is honorary chairman of the local Congress committee. The general chairman is Dr. George E. McKenzie of Miami, and heading the exhibits committee is Dr. Abraham R. Hollender of Miami Beach.



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One of the most convincing evidences of the anabolic activity of Nilevar, brand of norethandrolone, has been its ability to improve appetite and increase weight in poorly nourished, underweight children.

A highly important feature of the weight gain thus produced is that it is not ordinarily manifested by deposition of fat but as muscle tissue resulting from the protein anabolism induced by Nilevar.

Anorexia and "Weight Lag" Study—Brown, Libo and Nussbaum have reported* consistent and definite increases in rate of weight gain in eighty-six patients, ranging in age from 7 weeks to 15½ years. This beneficial action of Nilevar was observed in the patients with organic and traumatic disorders as well as those whose only complaints were poor appetite and/or persistent failure to gain weight.

In this study, the weight gained was not lost after discontinuance of Nilevar therapy although many patients did not continue the sharp gains effected by the drug.

The authors are of the opinion that Nilevar is a highly useful anabolic agent for influencing weight gain in underweight children.

When Nilevar is administered to children a dose of 0.25 mg. per pound of body weight is recommended and continuous dosage for more than three months is not recommended.

Nilevar is supplied as tablets of 10 mg., drops of 0.25 mg. per drop and ampuls of 25 mg. in 1 cc. of sesame oil. Further dosage information in Searle Reference Manual No. 4.

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Research in the Service of Medicine.

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*Brown, S. S.; Libo, H. W., and Nussbaum, A. H.: Norethandrolone in the Successful Management of Anorexia and "Weight Lag" in Children, Scientific Exhibit presented at the Annual Meeting of the American Academy of Pediatrics, Chicago, Oct. 20-23, 1958.

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The final date for submitting research requests for grants-in-aid to the Florida Heart Association is January 15, according to announcement by Dr. Paul N. Unger of Miami, chairman of the Association's Research Committee. Recipients of the grants will be announced April 30 at the annual meeting of the Association being held at the Balmoral Hotel in Miami Beach.

Dr. John B. Ross of Jacksonville presented a paper entitled "Myocardial Infarction Following Blood Donation" at the annual meeting of the American Association of Blood Banks held in Chicago in November.

Dr. Carlos P. Lamar of Miami spent two weeks at a Medical Congress in Guadalajara, Mexico, late in November where he presented two papers and participated in a panel discussion.

Dr. Sherman B. Forbes of Tampa attended the course on "Applied Ophthalmic Pathology" at the Grady Hospital in Atlanta on December 3-4.

The Florida Midwinter Seminar in Ophthalmology and Otolaryngology is scheduled for January 24-30 in the Americana Hotel at Miami Beach. Hotel reservations should be made direct with the Americana, Singapore, Balmoral or Sea Brook at Miami Beach. Special rates apply from January 23-31 inclusive.

A program on advances in Cardiovascular diseases will be held at the Cherry Plaza Hotel, Orlando, February 6, at 9:00 a.m. Guest speakers will be Dr. Andrew Morrow of the National Heart Institute, Bethesda, Md.; Dr. Charles Friedberg of Mt. Sinai Hospital, New York City; Dr. Harriet Dustan of the Cleveland Clinic and Dr. Philip Samet of Mt. Sinai Hospital, Miami Beach. There will be a morning and afternoon session. All physicians are invited to attend. Additional information may be obtained from Mrs. Emma Britt, Orange County Heart Association, 2904 N. Orange Ave., Orlando.

The Second Annual Hillsborough County and Suncoast Cardiovascular Seminar has been scheduled for Saturday and Sunday, February 20-21, at the Hillsboro Hotel in Tampa. The Seminar is jointly sponsored by the Hillsborough County Heart Association, Tampa, and the Suncoast Heart Association, St. Petersburg.

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COMPONENT SOCIETY NOTES

Brevard

Dr. Cyrus E. Warden of Melbourne has been elected president of the Brevard County Medical Society for the new year. Dr. Willard H. Bennett of Titusville who served as treasurer in 1959 has been chosen president-elect. Other officers elected at the Society's annual meeting include Dr. Carl J. Arnold Jr. of Cocoa vice president, Dr. John M. Gayden of Melbourne secretary and Dr. Joseph C. Von Thron of Cocoa Beach treasurer.

Collier

Dr. Loral F. Gwaltney of Naples has been installed as president of the Collier County Medical Society. Dr. Gwaltney was formerly vice president. Dr. John C. Garland also of Naples has been elected vice president. Other officers include Dr. Ethel H. Trygstad, secretary, and Dr. William J. Bailey, treasurer, who are from Naples. Both were re-elected.

Dade

Dr. Franklin J. Evans of Coral Gables has been inaugurated president of the Dade County Medical Association. Other officers elected at the annual meeting in December include Dr. Willard L. Fitzgerald also of Coral Gables as president-elect; Dr. DeWitt C. Daughtry of Miami as secretary and Dr. Paul S. Jarrett of Miami as treasurer. Dr. Daughtry previously served as secretary.

DeSoto-Hardee-Glades

Dr. Harold S. Agnew of Arcadia has been elected president of the DeSoto-Hardee-Glades County Medical Society. Chosen to serve with Dr. Agnew was Dr. Elmer J. Schmierer also of Arcadia as secretary-treasurer.

Duval

Dr. Floyd K. Hurt has been installed as president of the Duval County Medical Society, and Dr. Sidney Stillman who served the Society as treasurer last year has been elected president-elect. Dr. F. Gordon King has been elected vice president, Dr. Albert Rood, secretary and Dr. Robert J. Brown treasurer. All are from Jacksonville.

Hillsborough

Dr. Linus W. Hewit was inaugurated president of the Hillsborough County Medical Asso-

Announcing The Twenty-Third Annual Meeting of

THE NEW ORLEANS GRADUATE MEDICAL ASSEMBLY

Conference Headquarters — Roosevelt Hotel

March 7, 8, 9, 10, 1960

GUEST SPEAKERS

Leroy D. Vandam, M.D., Boston, Mass. Anesthesiology
Clarence S. Livingood, M.D., Detroit, Mich. Dermatology
Henry D. Janowitz, M.D., New York, N. Y. Gastroenterology
John G. Walsh, M.D., Sacramento, Calif. General Practice
E. Stewart Taylor, M.D., Denver, Colo. Gynecology
Charles H. Burnett, M.D., Chapel Hill, N. C. Internal Medicine
Peter C. Gazes, M.D., Charleston, S. C. Internal Medicine
Donald D. Matson, M.D., Boston, Mass. Neurosurgery
Frank R. Lock, M.D., Winston-Salem, N. C. Obstetrics
Trygve Gundersen, M.D., Boston, Mass. Ophthalmology
Carroll B. Larson, M.D., Iowa City, Ia. Orthopedic Surgery
John J. Conley, M.D., New York, N. Y. Otolaryngology
W. A. D. Anderson, M.D., Miami, Fla. Pathology
Franklin H. Top, M.D., Iowa City, Ia. Pediatrics
Raymond J. Jackman, M.D., Rochester, Minn. Proctology
David G. Pugh, M.D., Rochester, Minn. Radiology
Bentley P. Colcock, M.D., Boston, Mass. Surgery
Robert M. Zollinger, M.D., Columbus, Ohio Surgery
George C. Prather, M.D., Brookline, Mass. Urology

Lectures, symposia, clinicopathologic conferences, round-table luncheons, medical motion pictures and technical exhibits.

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Leaving March 12 from Port Everglades, Florida, and returning March 25, 1960.

For information concerning the Assembly meeting and the cruise write Secretary, Room 103, 1430 Tulane Avenue, New Orleans 12, La.

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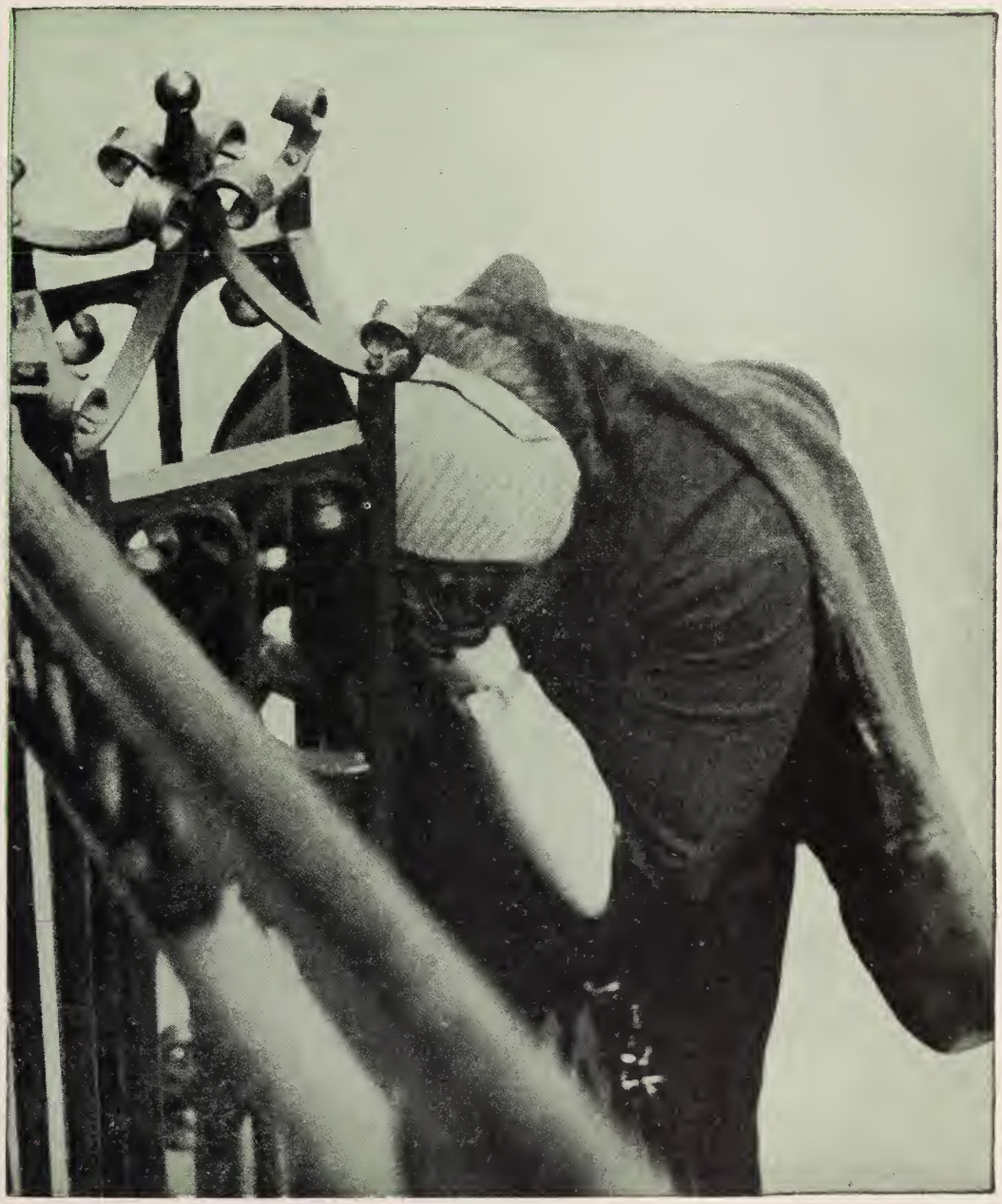

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ciation at the December meeting, and Dr. Herbert B. Lott was selected as president-elect. Other officers elected at the Association's annual meeting included Dr. Julien C. Pate Jr., first vice president; Dr. Leffie M. Carlton Jr., second vice president; Dr. Frank A. Massari, secretary, and Dr. Marvin B. Miller, treasurer, who was re-elected for another term. All are from Tampa.

Lake

Dr. W. Dean Steward of Orlando was principal speaker at the November meeting of the Lake County Medical Society held at Clermont. The subject of Dr. Steward's discussion was cardiac contusions.

Nassau

Dr. David D. Bennett Jr. of Callahan has been re-elected president of the Nassau County Medical Society. Dr. Cecil B. Brewton of Fernandina Beach has been re-elected secretary-treasurer.

Orange

"Relationship Between Pharmacists and Physicians" was the subject of a panel discussion at the November meeting of the Orange County Medical Society. The moderator was Arnold Albert, president, Central Florida Pharmaceutical Association. Panelists were Don Evans, Erwin Recu and William Mount, prominent Central Florida pharmacists.

Pasco-Hernando-Citrus

Dr. William H. Walters Jr. of Lacoochee has been elected president of the Pasco-Hernando-Citrus County Medical Society. Dr. Walters served as a vice president last year. Dr. Karl T. Humes of Bushnell and Dr. Warren A. Clark of Brooksville have been selected as vice presidents, and Dr. W. Wardlaw Jones of Dade City has been re-elected secretary-treasurer.

Pinellas

Dr. Chas. L. Farrington of St. Petersburg has been installed as president of the Pinellas County Medical Society, and Dr. Walter H. Winchester of Dunedin has been elected president-elect. Serving with Drs. Farrington and Winchester will be Dr. Edward L. Cole Jr of St. Petersburg as first vice president and Dr. Samuel T. Register of Clearwater as second vice president. Dr. Whitman C. McConnell of St. Petersburg was re-elected secretary-treasurer.

Sarasota

Dr. James E. Kicklighter was inaugurated president of the Sarasota County Medical Society at the December meeting, and Dr. George A. Bishopric became president-elect after serving the Society last year as secretary. Dr. Thomas G. Dickinson has been elected secretary, and Dr. Millard B. White has been re-elected treasurer. All are from Sarasota.

Volusia

The film and recorded address "Aging—A Community Responsibility" by Dr. Louis M. Orr of Orlando, President of the American Medical Association, was a feature of December meeting of the Volusia County Medical Society held at Ormond Beach.

Dr. James J. Cunningham of New Smyrna Beach has been installed as president of the Society, and Dr. C. Robert DeArmas of Daytona

(Continued on page 884)

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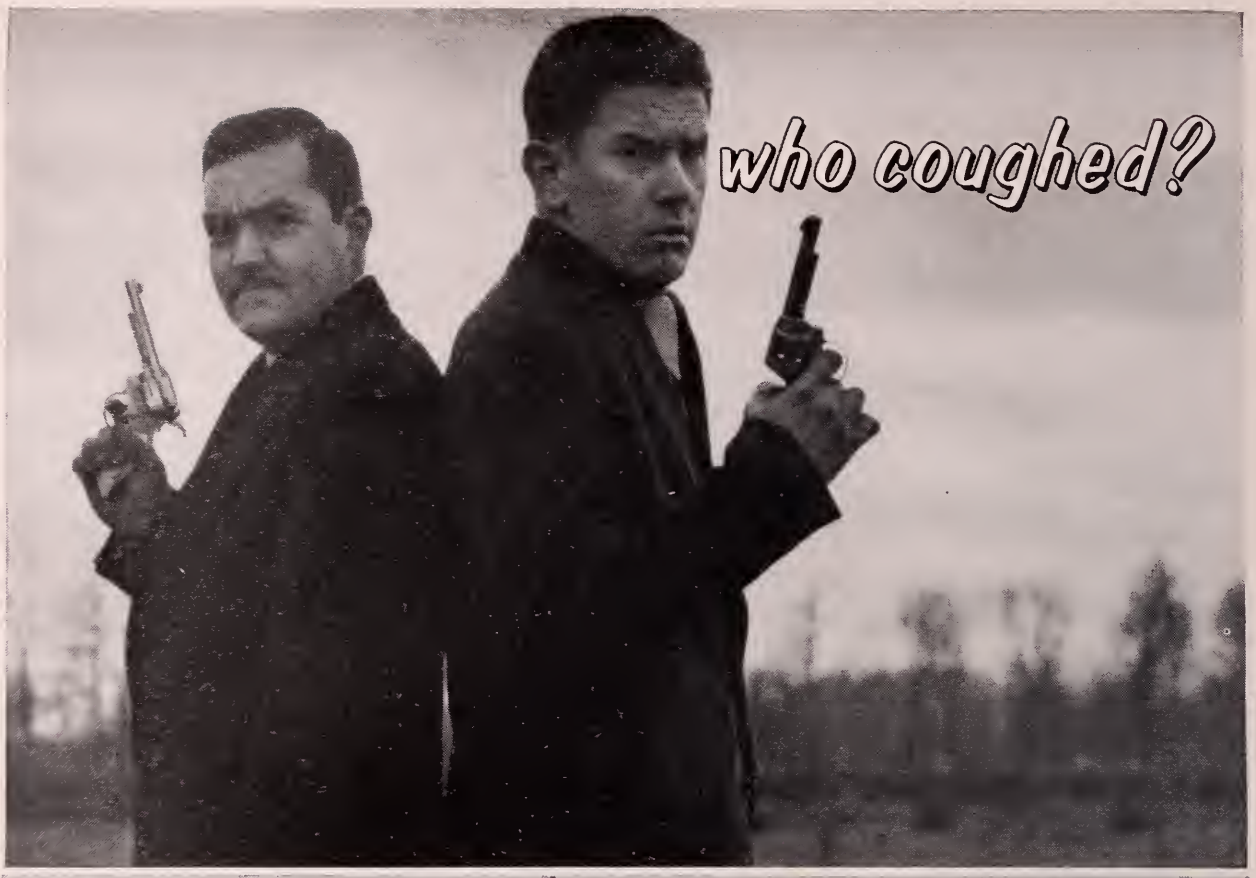

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Dihydrocodeinone Bitartrate (Warning: May be habit-forming)	5 mg.	6.5 mg.
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Ammonium Chloride		60 mg.
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Dosage—1 or 2 capsules 3 or 4 times a day.
Supplied—Capsules containing Panmycin phosphate equivalent to 250 mg. tetracycline hydrochloride, and 125 mg. Albamycin as novobiocin sodium, in bottles of 16 and 100.
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Ensey, J. E.: Am. J. Obst. 77:155, 1959

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- Achieves clinical and cultural cures where others fail
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2. SUPPOSITORIES for continued home use each morning and night the first week and each night thereafter—especially during the important menstrual days. MICOFUR 0.375% and FUROXONE 0.25% in a water-miscible base.

Rx new box of 24 suppositories with applicator for more practical and economical therapy.

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In each Allbee with C:		As much as:*
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Nicotinamide	50 mg.	11 ozs. of roasted peanuts
Calcium pantothenate	10 mg.	¼ lb. of fried beef liver
Ascorbic acid (Vitamin C)	**250 mg.**	¾ lb. of cooked broccoli

*These common foods are among the richest sources of B vitamins and ascorbic acid. H. A. Wooster, Jr., Nutritional Data, 2nd Ed., Pittsburgh, 1954.

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the beauty of these antitussives:

they help the cough remove its cause

These elegant antitussives comprise a group of significantly superior expectorants from which you may select the formula best suited for your coughing patient.

First of all, they have more in common than mere delectability to eye and palate: they all include *glyceryl guaiacolate*. This remarkable expectorant aids the coughing mechanism by increasing the secretion of Respiratory Tract Fluid,[1] which helps liquefy sputum,[1,3] makes bronchial and tracheal cilia more efficient,[1,2] and acts as a demulcent.[1,3-5] Through its effects, all four expectorants promote the natural purpose of the cough, which is to remove the irritants that cause it.[1,2]

In addition, the Robins antitussive armamentarium provides a choice of widely accepted drugs in various combinations with glyceryl guaiacolate for treating different kinds of coughs and associated symptoms. For antihistaminic effects, there is Dimetane® or prophenpyridamine; for bronchodilation and nasal decongestion, there are sympathomimetic agents; and for suppression of the "too frequent" cough, there is codeine or dihydrocodeinone.

Robitussin®

Each teaspoonful contains:
Glyceryl guaiacolate ..... 100 mg.

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Each teaspoonful contains:
Glyceryl guaiacolate ..... 100 mg.
Prophenpyridamine maleate ... 7.5 mg.
Codeine phosphate ..... 10 mg.
(exempt narcotic)

Dimetane® Expectorant

Each teaspoonful contains:
Parabromdylamine maleate (DIMETANE) ..... 2 mg.
Glyceryl guaiacolate ..... 100 mg.
Phenylephrine HCl, USP ..... 5 mg.
Phenylpropanolamine HCl, NNR ..... 5 mg.

Dimetane® Expectorant-DC

Each teaspoonful contains the Dimetane Expectorant formula *plus* Dihydrocodeinone bitartrate, NF ..... 1.8 mg.
(exempt narcotic)

References: 1. Cass, L. J., and Frederik, W. S.: Am. Pract. & Digest Treat. *2*:844, 1951. 2. Blanchard, K., and Ford, R. A.: Journal-Lancet *74*:443, 1954. 3. Hayes, E. W., and Jacobs, L. S.: Dis. Chest *30*:441, 1956. 4. Blanchard, K., and Ford, R. A.: Rocky Mountain M. J., Vol. 52, No. 3, 1955. 5. Boyd, E. M., and Pearson: Am. J. M. Sc. *211*:602, 1946.

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(Continued from page 876)

Beach has been elected president- elect. Chosen at the November meeting to serve with Drs. Cunningham and DeArmas were Dr. Carroll M. Crouch of Daytona Beach as treasurer and Dr. John J. Cheleden of Daytona Beach, who will be serving a second term, as secretary.

Walton-Okaloosa-Santa Rosa

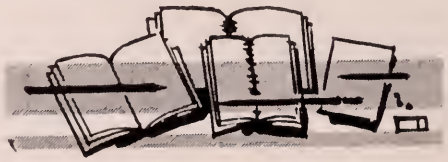
Dr. Joseph C. Wilson has been elected president of the Walton-Okaloosa-Santa Rosa County Medical Society. Serving with Dr. Wilson this year will be Dr. Frederick F. Crews as vice president, Dr. William W. Thompson as secretary and Dr. Frederic E. Caldwell as treasurer. All the officers are from Fort Walton Beach.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Bennett, Joseph J., West Hollywood
Bradley, Donald J., Pensacola
Catanzaro, Santino J., Ft. Lauderdale
Cox, John M. (Col.), Orlando
Delgado, Robert E., Orlando
Edwards, Jefferson R. Jr., Pompano Beach
Ellis, Woodrow G., Pompano Beach
Hirsh, John H., Ft. Lauderdale
Holder, W. Lewis, Ft. Lauderdale
Monaco, A. Ralph, Panama City
Montgomery, Brian K., Pensacola
Olsen, O. Edwin, Orlando
Wiener, Harvey, Hollywood
Rapaport, Stanley L., Fern Park
Shephard, Juddson E., Winter Park
Simon, Roy L., Ft. Lauderdale

EIGHTY-SIXTH Annual Meeting
FLORIDA MEDICAL ASSOCIATION



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OBITUARIES

Anna Albertina Darrow

Dr. Anna Albertina Darrow died at her home in Coral Gables on July 22, 1959. She was 83 years of age. Funeral services and interment took place in Fort Lauderdale.

Born on a farm in Jasper County, Indiana, in 1876, Dr. Darrow on her twentieth birthday was married to Mr. Charles Roy Darrow, and they soon decided to study medicine together. After two years, she was graduated with highest honors from the Kirksville School of Osteopathy, and her husband ranked second in the class. Using osteopathy as a steppingstone, they then enrolled in the Chicago College of Medicine and Surgery, now the Stritch School of Medicine of Loyola University, practicing osteopathy at night and studying medicine in the day. Again, she was graduated with honors in the class of 1909. When she took her Florida State Board examination that same year, she made the highest mark ever received up to that time. The Darrows entered the private practice of medicine in Jacksonville in 1910 and rapidly built up a successful practice.

In 1912, when Mr. Henry Flagler asked Dr. Charles Darrow to become the District Railroad Surgeon in the Okeechobee area, the couple eagerly accepted the challenge and for years were the only physicians in that undeveloped region. They made their home in the new town of Okeechobee when streets were not yet laid out and only Indian trails led to it. There Dr. Anna Darrow continued to practice for more than a decade while her husband, in failing health, devoted most of his interests to the drugstore which they opened. Armed with her therapeutic armamentarium of quinine, calomel, and a kit of homeopathic drugs presented to her by Mr. Abbott himself, this intrepid general practitioner rode horseback over a radius of 40 miles on her errands of mercy and won particular distinction for her work with the Seminole Indians of Southern Florida. Later, the Darrows practiced in Stuart for several years and then moved to Fort Lauderdale, where Dr. Charles Darrow died.

After the untimely death of her husband in 1926, Dr. Darrow continued to practice medicine in Fort Lauderdale for almost a quarter of a century. Art was her avocation, and at the American Medical Association convention in 1947 she

DBI

trademark, brand of Phenformin HCl

the "full-range" oral hypoglycemic agent
...safely lowers blood sugar in mild, moderate and severe diabetes, in children and adults

start
low

entered in the Mead Johnson Contest on the theme of "Devotion Over and Above the Call of Duty" a picture portraying the dangers she encountered in the snake-infested swamps in the course of her practice. This most prized possession, which won second prize and an award of a thousand dollars, she bequeathed to the Broward County Medical Association. Locally, she was active in the Fort Lauderdale Women's Club, the Fort Lauderdale Business and Professional Women's Club, of which she was a charter member, and the Order of Eastern Star. Upon her retirement in 1949, she made her home in Coral Gables.

One of the founders of the Broward General Hospital, Dr. Darrow was for many years an active member of the Broward County Medical Association. She was a founder of the South Florida branch of the Women's Medical Association and remained active in it even after she retired. For 46 years she held membership in the Florida Medical Association, and she was also a member of the American Medical Association, the Southern Medical Association and the American Women's Medical Association.

Surviving are a daughter, Miss Dorothy Darrow, of Coral Gables; a son, Richard Gordon Darrow, of Tucson, Ariz.; a grandson, Dr. Kent Darrow, of Hollywood, Calif.; and a great-granddaughter.

Marvin Henry Smith

Dr. Marvin Henry Smith of Miami died at his home in Coral Gables on July 23, 1959, from the effects of generalized carcinomatosis. He was 80 years of age.

A native of Florida, Dr. Smith was born in Umatilla on Dec. 16, 1878. He was graduated from the Southern College of Pharmacy and the Dixie Business College of Atlanta before attending the Atlanta School of Medicine, later Emory University School of Medicine, where he was awarded his medical degree in 1910.

Dr. Smith practiced in Jacksonville for 12 years before moving to Orlando in 1925. After practicing there for two years, he went to Miami, limited his practice to gastroenterology, and continued to practice in that city for 32 years, except for the years 1933 to 1935 which he spent in postgraduate work in Europe. He also engaged

(Continued on page 902)

The **"Start Low! Go Slow!"** dosage pattern with DBI enables a maximum number of diabetics to enjoy the convenience, comfort and satisfactory regulation of oral therapy in:

stable adult diabetes
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sulfonylurea resistant diabetes

"Start Low! Go Slow" means low initial dosage (25 mg., or 50 mg. in divided doses, per day) with small dosage increments (25 mg.) every 3rd or 4th day until blood sugar levels are adequately controlled. Injected insulin is reduced gradually with each increase in DBI dosage. Satisfactory regulation of mild stable diabetes is usually achieved with DBI alone.*

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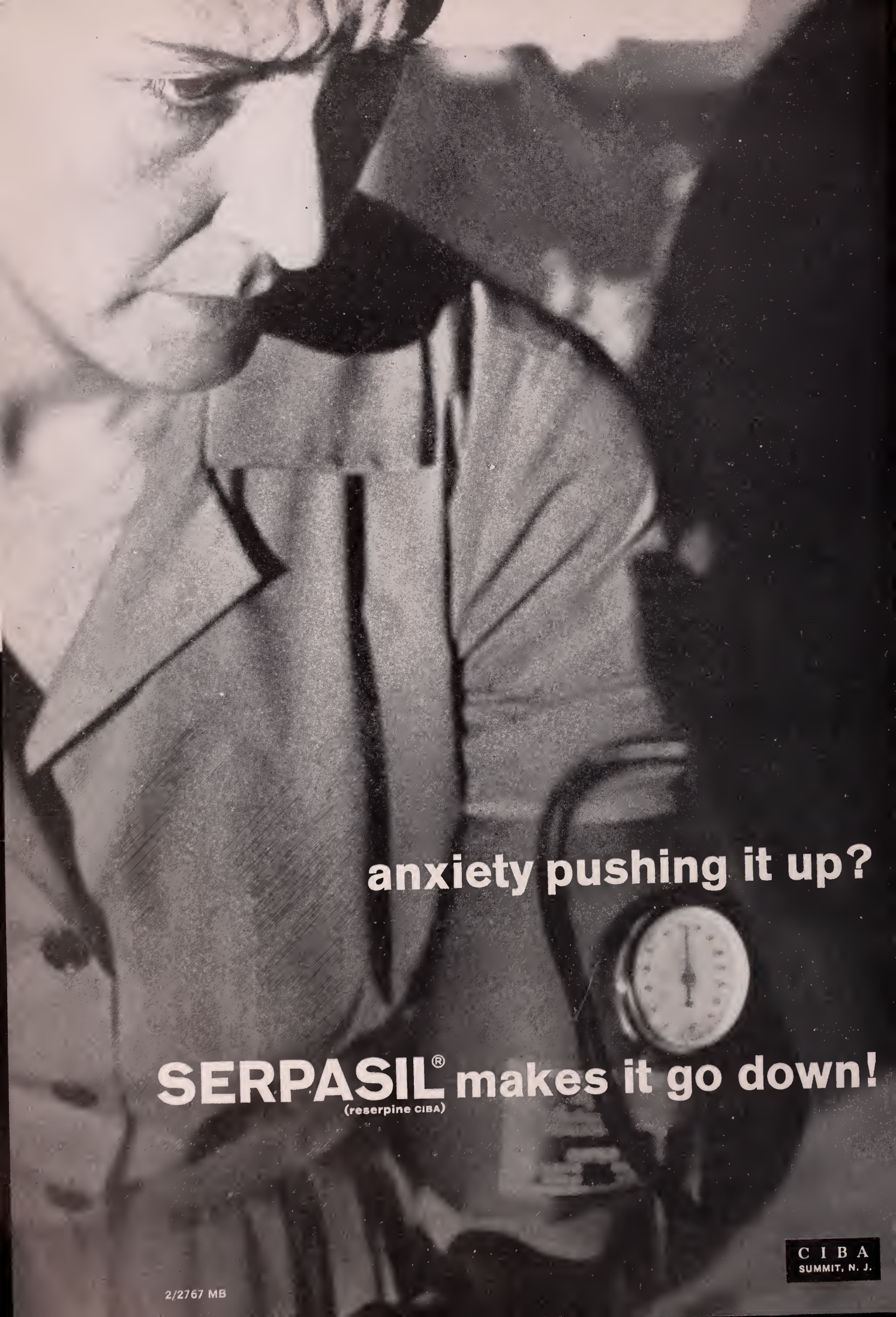
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NO SALT... *but seasoned*

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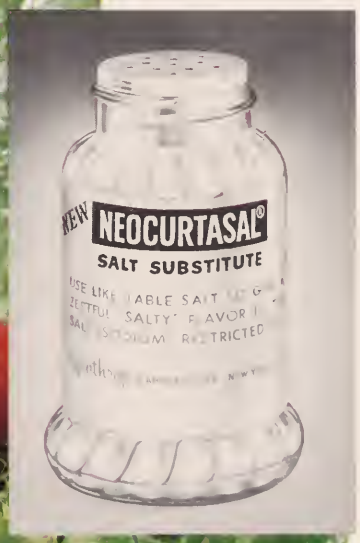

Neocurtasal contains potassium chloride, potassium glutamate, glutamic acid, calcium silicate and potassium iodide (0.01 per cent)

Supplied in 2 oz. shakers and 8 oz. bottles.

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"Whatever else may be needed from time to time in the management of individual cases, these drugs [Plaquenil and Aralen] should always be given a prolonged trial (at least six months) as the 'mainstay' of therapy."

Bagnall, A. W. (Univ. British Columbia, Vancouver, B.C.): A.M.A. Clinical Meeting (Scientific Section, Exhibit No. 124), Minneapolis, Minnesota, Dec. 2-5, 1958.

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Scherbel, A. L.; Harrison, J. W., and Atdjian, Martin: Cleveland Clin. Quart. *25:95, April, 1958.*

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Cramer, Quentin (Kansas City): Missouri Med. *55:1203, Nov., 1958.*

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depresses appetite
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...without
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Each coated tablet (pink) contains:
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bring all of her concepts of cleansing

Many women don't know that a vinegar douche is as old-fashioned as the copper tub, a relic of an empiric age.[1] Acids actually make mucus discharge more tenacious. On the other hand, soaps and harsh alkali are irritating. A detergent douche — TRICHOTINE, the only major douche containing sodium lauryl sulfate — is the modern, more efficient yet gentler vaginal irrigant.

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If there is any doubt in your mind, compare TRICHOTINE with vinegar or any other

1. Goodman, L.S. and Gilman, A.: The Pharmacologic Basis of Therapeutics, MacMillan, 1955.

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2. Karnaky, K.J.: J.A.M.A. 157:1155, 1955 (August)
3. Scheinberg et al: Surgery 24:972, 1948 (Dec.).

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Erythrocin®

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Acetylsalicylic Acid 2½ gr. .	(162 mg.)
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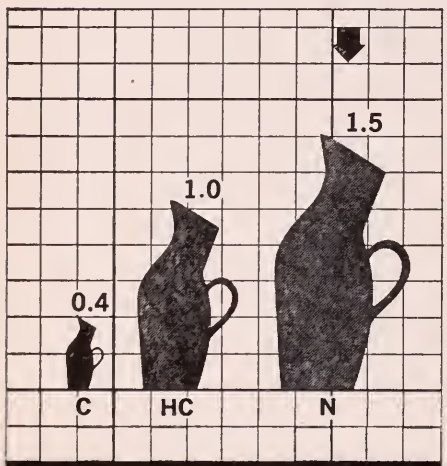
Naturētin

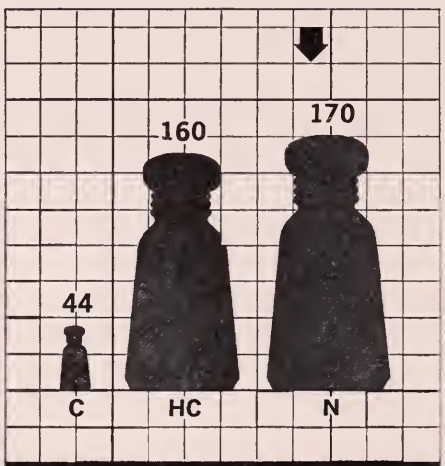
Squibb Benzydroflumethiazide

"When compared to other members of this heterocyclic grou of compounds, this drug [NATURETIN] shows a significantly in creased natriuresis and decreased loss of potassium and bicar bonate. In this respect it more closely approaches a natural o 'ideal diuretic.' It is effective upon continuous administration an causes no significant serum biochemical changes. It is effectiv in a wide variety of edematous and hypertensive states an represents a significant advance in diuretic therapy." *Ford, R.V Pharmacological observations on a more potent benzothiadiazi diuretic; accepted for publication by the American Heart Journ*

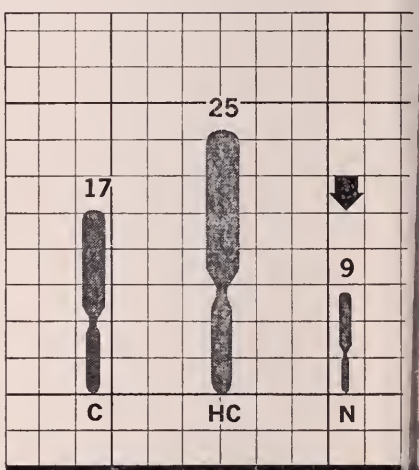
Comparison of electrolyte excretion pattern for the 24 hours followin typical doses of chlorothiazide, hydrochlorothiazide, and Naturetir



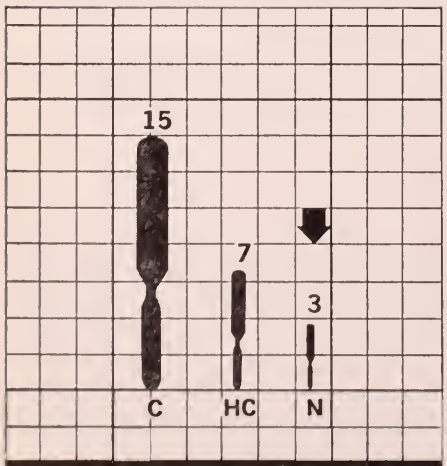
Urinary Volume (liters)
significantly increased
with Naturetin



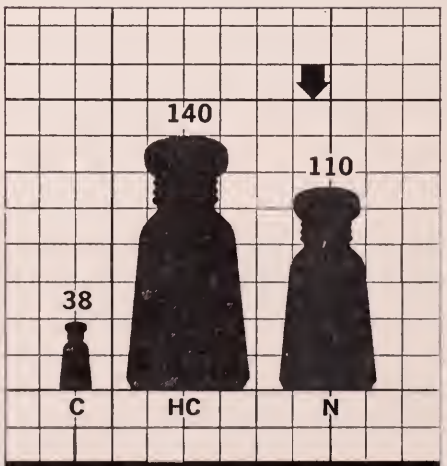
Natriuresis (mEq./24 hr.)
sodium excretion significantly
increased with Naturetin



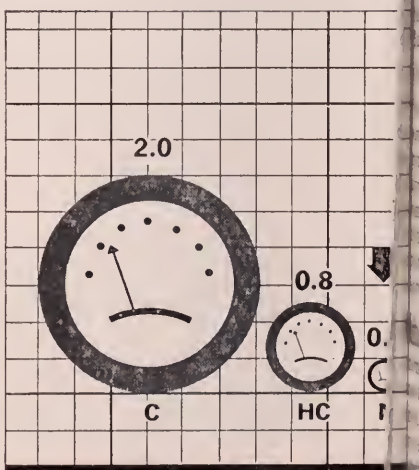
Potassium Excretion
(mEq./24 hr.)
least with Naturetin



Bicarbonate Excretion
(mEq./24 hr.)
least with Naturetin



Chloride Excretion
(mEq./24 hr.)
marked increases



Urinary pH
least increase with Naturetin

Typical Doses: Chlorothiazide—1,000 mg.; Hydrochlorothiazide—50 mg.; Naturetin (Benzydroflumethiazide)—5 m

1. Adapted from: Ford, R. V., Squibb Clin. Res. Notes 2:1 (Dec.) 1959

A single 5 mg. tablet once a day provides all these advantages[2]

- prolonged action — in excess of 18 hours
- convenient once-a-day dosage
- low daily dosage — more economical for the patient
- no significant alteration in normal electrolyte excretion pattern
- repetitively effective as a diuretic and antihypertensive
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- potency maintained with continued administration
- low toxicity — few side effects — low salt diets not necessary
- comparative studies with chlorothiazide, hydrochlorothiazide, and Naturetin disclose that smallest doses of Naturetin produce greater weight loss per day
- in hypertension, Naturetin, alone or in combination with other anti-hypertensives, produces significant decreases in mean blood pressure and other favorable clinical effects
- purpura and agranulocytosis not observed
- allergic reactions rarely observed

[2]Reports (1959) to the Squibb Institute for Medical Research.

ıturētin —*Indications:* in control of edema when diuresis is required, in congestive heart failure, the premenstrual syndrome, nephrosis and nephritis, cirrhosis with ascites, edema induced by drugs ertain steroids); in the management of hypertension, used alone, combined with Raudixin (Squibb ıuwolfia Serpentina Whole Root), or with other antihypertensive drugs, such as ganglionic blocking agents.

ntraindications: none, except in complete renal shutdown.

ecautions: when Naturetin is added to an antihypertensive regimen including hydralazine, ratrum, and/or ganglionic blocking agents, immediate reduction must be made in the dosage for all eparations; the dosage for ganglionic blocking agents must be decreased by 50% to avoid a precipitous op in blood pressure. This also applies if these hypotensive drugs are added to an established Naturetin gimen . . . in hypochloremic alkalosis with or without hypokalemia . . . in cirrhotic patients or those on gitalis therapy when reductions in serum potassium are noted . . . in diabetic patients or those edisposed to diabetes . . . when increased uric acid concentrations are noted . . . when signs— g or abdominal cramps, pruritus, paresthesia, rash—suggestive of hypersensitivity, are noted.

ıturētin —*Dosage: in edema,* average dose, 5 mg., once daily, preferably in the orning; to initiate therapy, up to 20 mg., once daily or in divided doses; for aintenance, 2.5 to 5.0 mg., daily in a single dose. *In hypertension:* suggested itial dose, 5 to 20 mg. daily; for maintenance, 2.5 to 15 mg. daily, depending the individual response of the patient. When Naturetin is added to an anti-pertensive regimen with other agents, lower maintenance doses of each ug should be used.

ıturētin —*Supplied:* tablets of 2.5 mg. and 5 mg. (scored).

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Ingredient

Rx
Naturetin 5mg.
Disp. #30
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truly repository injectable B_{12} quickly achieves and sustains high B_{12} blood levels for a minimum of 28 days

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Each package of Depinar consists of a multiple dose vial, containing cyanocobalamin zinc tannate (lyophilized) equivalent to 2500 mcg. vitamin B_{12}. The vial of diluent contains 5 cc. Sodium Chloride Solution for Injection. When reconstituted, each ml. of Depinar contains 500 mcg. vitamin B_{12}.

*Thompson, R. E., and Hecht, R. A.: Am. J. Clin. Nutrition 7:311-317 (May-June) 1959.

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for the tense and nervous patient

relief comes fast and comfortably

–does not produce autonomic side reactions
–does not impair mental efficiency, motor control, or normal behavior.

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Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets or as MEPROTABS*—400 mg. *unmarked*, coated tablets.

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TRAUMATIC STRAINS AND BRUISES

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■ Exhibits unusual analgesic properties, different from those of any other drug ■ Specific and superior in relief of SOMAtic pain

■ Modifies central perception of pain without abolishing natural defense reflexes ■ Relaxes abnormal tension of skeletal muscle

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N-isopropyl-2-methyl-2-propyl-1, 3-propanediol dicarbamate

■ More specific than salicylates ■ Less drastic than steroids

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SOMA has an unique analgesic action. It apparently modifies central pain perception without abolishing peripheral pain reflexes. SOMA is particularly effective in relieving joint pain. Patients say that they feel better and sleep better with SOMA than with previously used analgesic, sedative or relaxant drugs.
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ACTS FAST. Pain-relieving and relaxant effects start in 30 minutes and last 6 hours.

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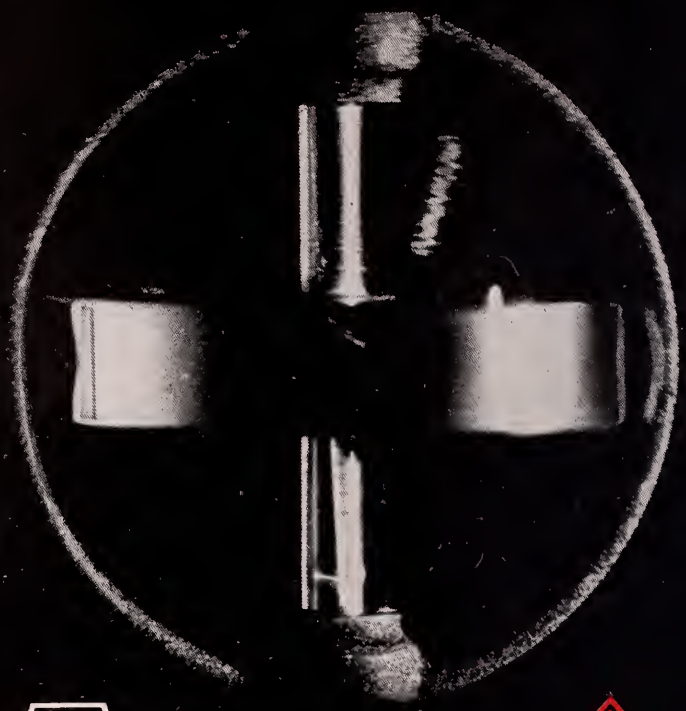
minimal disturbance
of the patient's chemical and psychic balance . . .



still unsurpassed for total corticosteroid benefits

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Substantiated by published reports of leading clinicians:

- **effective control** of allergic and inflammatory symptoms[1-20]
- **minimal disturbance** of the patient's chemical and psychic balance[1, 4, 5, 8-19]

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-inflammatory and antiallergic levels ARISTOCORT means:

'reedom from salt and water retention

virtual freedom from potassium depletion

negligible calcium depletion

euphoria and depression rare

no voracious appetite—no excessive weight gain

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low incidence of osteoporosis with compression fracture

: rheumatoid arthritis; arthritis; respiratory allergies; allergic and inflammatory ; disseminated lupus erythematosus; nephrotic syndrome; lymphomas and leukemias.

:: With ARISTOCORT all traditional precautions to corticosteroid therapy should be ob-

age should always be carefully adjusted to the smallest amount which will suppress After patients have been on steroids for prolonged periods, discontinuance must be gradually.

Scored tablets of 1 mg. (yellow); 2 mg. (pink); 4 mg. (white); 16 mg. (white).

'arenteral (for intra-articular and intrasynovial injection). Vials of 5 cc. (25 mg./cc.).

References: 1. Feinberg, S.M., Feinberg, A.R., and Fisherman, E.W.: *J.A.M.A.* 167:58 (May 3) 1958. 2. Epstein, J.I. and Sherwood, H.: *Connecticut Med.* 22:822 (Dec.) 1958. 3. Friedlaender, S. and Friedlaender, A.S.: *Antibiotic Med. & Clin. Ther.* 5:315 (May) 1958. 4. Segal, M.S. and Duvenci, J.: *Bull. Tufts North East M. Center* 4:71 (April-June) 1958. 5. Segal, M.S.: Report to the A.M.A. Council on Drugs, *J.A.M.A.* 169:1063 (March 7) 1958. 6. Sherwood, H. and Cooke, R.A.: *J. Allergy* 28:97 (Mar.) 1958. 7. Duke, C.J. and Oviedo, R.: *Antibiotic Med. & Clin. Ther.* 5:710 (Dec.) 1958. 8. McGavack, T.H.: *Clin. Med.* (June) 1958. 9. Freyberg, R.H.; Berntsen, C.A., and Hellman, L.: *Arthritis and Rheumatism* 1:215 (June) 1958. 10. Hartung, E.F.: *J.A.M.A.* 167:973 (June 21) 1958. 11. Hartung, E.F.: *J. Florida Acad. Gen. Pract.* 8:18, 1958. 12. Zuckner, J.; Ramsey, R.H.; Caciolo, C., and Gantner, G.E.: *Ann. Rheum. Dis.* 17:398 (Dec.) 1958. 13. Appel, B.; Tye, M.J., and Leibsohn, E.: *Antibiotic Med. & Clin. Ther.* 5:716 (Dec.) 1958. 14. Kalz, F.: *Canad. M.A.J.* 79:400 (Sept.) 1958. 15. Mullins, J.F., and Wilson, C.J.: *Texas State J. Med.* 54:648 (Sept.) 1958. 16. Shelley, W.B.; Hanna, J.S., and Pillsbury, D.M.: *J.A.M.A.* 167:959 (June 21) 1958. 17. DuBois, E.F.: *J.A.M.A.* 167:1590 (July 26) 1958. 18. McGavack, T.H.; Kao, K.T.; Leake, D.A.; Bauer, H.G., and Berger, H.E.: *Am. J. Med. Sc.* 236:720 (Dec.) 1958. 19. Council on Drugs: *J.A.M.A.* 169:257 (Jan. 17) 1959. 20. Rein, C.R.; Fleischmajer, R., and Rosenthal, A.R.: *J.A.M.A.* 165:1821 (Dec. 7) 1957.

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(Continued from page 889)

in postgraduate study at the New York Post-Graduate School and Hospital and the New York Polyclinic Medical School and Hospital. Locally, he was on the staff and at one time head of the Gastro-Intestinal Department of Jackson Memorial Hospital, and he was a member of the visiting staff of the Veterans Administration Hospital in Coral Gables. He was the inventor of several surgical instruments for use in gastrointestinal surgery. He was a Mason and a Shriner, and was a member of the First Methodist Church of Coral Gables.

A member of the Dade County Medical Association, Dr. Smith was a life member of the Florida Medical Association, having held membership for 46 years, and was a member of the American Medical Association. He was a founder member and past president of the Southern Gastro-Enterological Association, and was a fellow of the American College of Gastroenterology. He was also a member of the American Association for the Advancement of Science.

Surviving are the widow, Mrs. Corrie Smith; three daughters, one son, two brothers and one sister.

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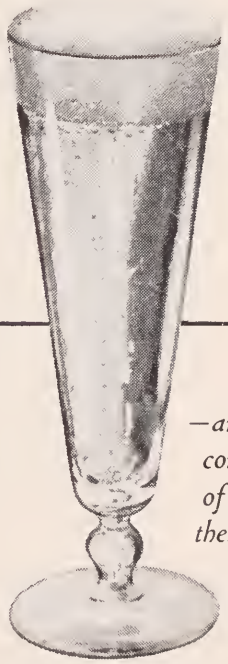

—and, with your consent, a glass of beer to make them even better

The High-Vitamin, High-Mineral Diet

Shredded new cabbage and carrot slaw goes nicely with any meal, combining vitamins A, C, and calcium. Dried apricots and figs stuffed with cottage cheese and peanuts on watercress provide calcium, iron, vitamins A, E_2, niacin and C. Oysters are rich in iron, calcium and carry vitamins A and D, too.

Beef liver ranks high in iron, vitamins A and B-complex. Oatmeal, rich in iron, gets a calcium and vitamin B_6 bonus when served with molasses and milk. Custard contains calcium and vitamins A, B_1, B_2. A topping of orange juice concentrate adds Vitamin C.

And with a glass of beer*—at your discretion—your patient will find his diet interesting and ample without straying from your instructions.

*An 8-oz. glass of beer contains 10 mg. calcium, 50 mg. phosphorus, ⅓ minimum daily requirement of niacin, and smaller amounts of other B-complex vitamins. (Average of American beers)

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(—and the most exacting appetites).

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Wesson's Important Ingredients:

Linoleic acid glycerides	50% to 55%
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Never hydrogenated—completely salt free

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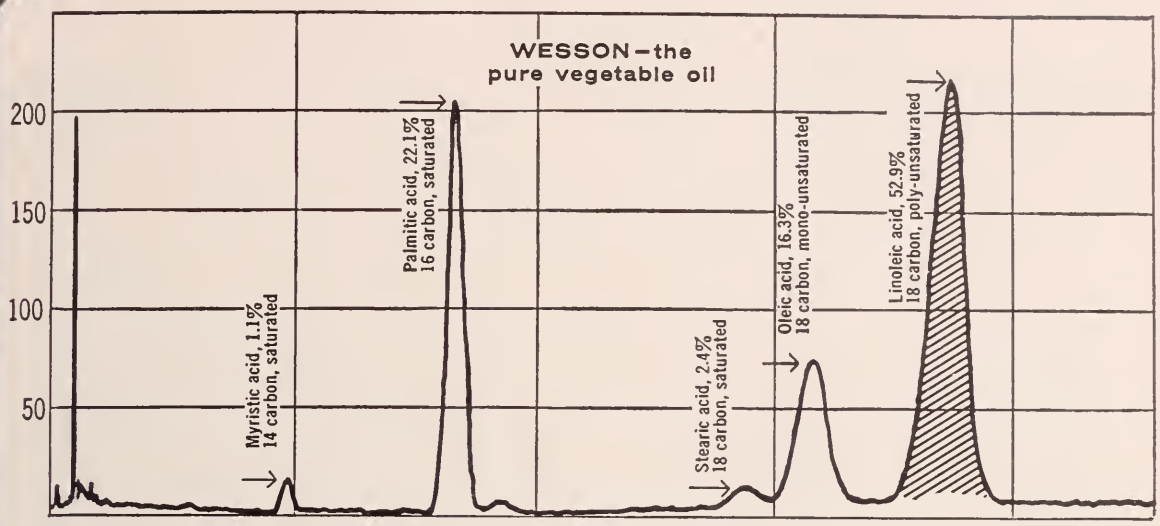

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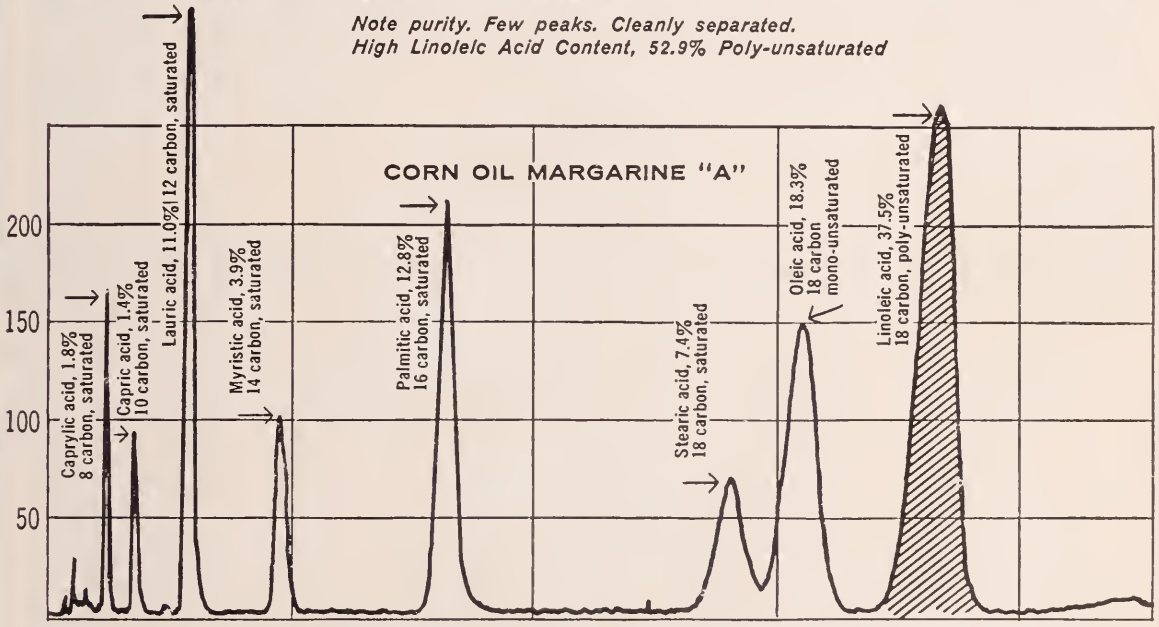
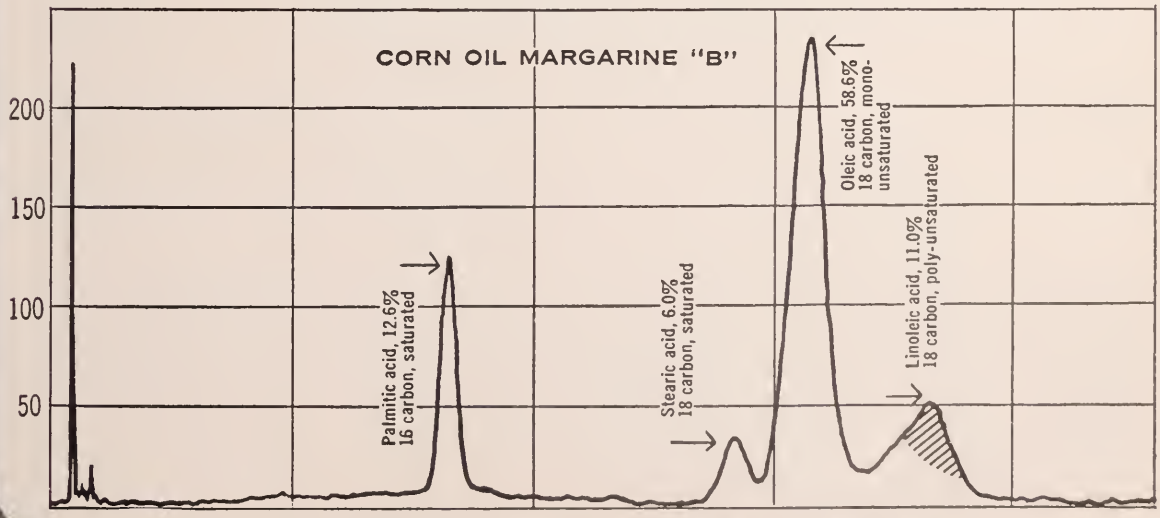
High Linoleic Acid Content, 52.9% Poly-unsaturated



Note effect of coconut oil. Medium Linoleic Acid Content, 37.5%



Note effect of hydrogenation. Low Linoleic Acid Content, 11%

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Sterazolidin® capsules

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Geigy

with less risk of disturbing hormonal balance

In the treatment of the rheumatic disorders new Sterazolidin provides a method of limiting the gravest danger inherent in steroid therapy... hypercortisonism arising from excessive dosage.

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1. Kuzell, W. C., and others.: Arch. Int. Med. 92:646, 1953. 2. Wolfson, W. Q.: J. Michigan M. Soc. 54:323, 1955. 3. Strandberg, B.: Brit. J. Phys. Med. 19:9, 1956. 4. Platt, W. D., Jr., and Steinberg, I. H.: New England J. Med. 256:823 (May 2) 1957.

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DECLOMYCIN singularly achieves:

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- unsurpassed broad-spectrum range of activity[4,6,10-12,14]
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Milligram for milligram, DECLOMYCIN brand of Demethylchlortetracycline has two to four times the inhibitory capacity of tetracycline against susceptible organisms. Thus, DECLOMYCIN has the advantage of providing significantly higher serum *activity* levels with significantly reduced drug intake.*

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*Activity level is a far more meaningful basis of comparison than quantitative blood levels, as Hirsch and Finland note. Action upon pathogens is the ultimate value. (Hirsch, H. A. and Finland, M.: Antibacterial Activity of Serum of Normal Subjects after Oral Doses of Demethylchlortetracycline, Chlortetracycline and Oxytetracycline. *New England J. Med.* 260:1099 (May 28) 1959.)

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The high level of DECLOMYCIN activity is uniquely sustained. It is not just an initial phenomenon but is constant—maintained on each day of treatment and between doses—without noticeable diminution of intensity. Peak-and-valley control is eliminated, favoring continuous suppression of pathogens and consequent improvement.

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Reports presented at Seventh Annual Symposium on Antibiotics, Mayflower Hotel, Washington, D. C., November 4-6, 1959: 1. Boger, W. P. and Gavin, J. J.: Demethylchlortetracycline: Serum Concentration Studies and Cerebrospinal Fluid Diffusion. 2. Chávez Max, G.: Therapeutic Evaluation of Demethylchlortetracycline in Human Brucellosis. 3. Duke, C. J.; Katz, S., and Donohoe, R. F.: Demethylchlortetracycline in the Treatment of Pneumonia. 4. Finland, M.; Hirsch, H. A., and Kunin, C. M.: Observations on Demethylchlortetracycline. 5. Fujii, R.; Ichihashi, H.; Minamitani, M.; Konno, M., and Ishibashi, T.: Clinical Results with Demethylchlortetracycline in Pediatrics and Comparative Studies with Other Tetracyclines. 6. Garrod, L. P. and Waterworth, P. M.: The Relative Merits of the Four Tetracyclines. 7. Kanof, N. B. and Blau, S.: A Clinical Evaluation of Declomycin Demethylchlortetracycline in the Treatment of Pustular Dermatoses. 8. Kunin, C. M.; Dornbush, A. C., and Finland, M.: Distribution and Excretion of Four Tetracycline Analogues in Normal Men. 9. Marmell, M. and Prigot, A.: The Use of Demethylchlortetracycline in Gonorrhea, Lymphogranuloma Venereum, and Donovanosis. 10. Olarte, J.: The Sensitivity of Selected Strains of Shigella, Salmonella and Enteropathogenic *Escherichia coli* to Demethylchlortetracycline and Tetracycline. 11. Perry, D. M.; Hall, G. A., and Kirby, W. M. M.: Demethylchlortetracycline: A Clinical and Laboratory Appraisal. 12. Roberts, M. S.; Seneca, H., and Lattimer, J. K.: Demethylchlortetracycline in Genitourinary Infections. 13. Ross, S.; Puig, J. R.; and Zaremba, E. A.: Absorption of Demethylchlortetracycline in Infants and Children: Some Preliminary Observations. 14. Vineyard, J. P.; Hogan, J., and Sanford, J. P.: Clinical and Laboratory Evaluation of Demethylchlortetracycline.

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BOOKS RECEIVED

Surgery in World War II, Neurosurgery, Volume I. Editor in Chief, Colonel John Boyd Coates, Jr., MC; Editors for Neurosurgery, R. Glen Spurling, M. D., and Barnes Woodhall, M. D.; Associate Editor, Elizabeth M. McFetridge, M. A. Pp. 466. Illus. 130. Price, $5.00. Washington, D. C., Office of the Surgeon General, Department of the Army, 1958.

This book is the first of two volumes dealing with neurosurgery which are part of the official History of the Medical Department, US Army, in World War II. It covers administrative considerations and head injuries, and Volume II, to be published during 1959, will deal with injuries of the spinal cord and of the peripheral nerves. In addition to the distinguished editors, there are 12 outstanding contributors. As in other volumes of the official history, there is much in this story of military neurosurgery that is applicable to peacetime practice. The administrative section of this volume tells in detail of the establishment and operation of neurosurgical centers specially equipped and staffed with the best neurosurgical talent available—the efficient administrative set-up which enabled the professional skills of all concerned to be employed to the best advantage. It also tells how existing shortages in personnel were overcome by a program of rapid specialized training of carefully selected, already well trained general surgeons. Included in the discussion of head injuries in the second section of the book are (1) the management of acute craniocerebral injuries due to missiles; (2) penetrating wounds of the cerebral ventricles; (3) blast concussion and cerebral injuries due to explosion waves; (4) clinicopathologic aspects of fatal missile-caused craniocerebral injuries; (5) cranioplasty; (6) post-traumatic epilepsy; (7) speech disorders resulting from gunshot wounds of the head and neck, and (8) infections following acute gunshot wounds of the brain.

Diseases of Metabolism. *Detailed Methods of Diagnosis and Treatment.* By Garfield G. Duncan, M.D. Ed. 4. Pp. 1104. Illus. 226. Price, $18.50. Philadelphia, W. B. Saunders Company, 1959.

This timely volume affords an unusually practical basis for the understanding and treatment of all the various metabolic disorders commonly met in daily patient care. The 22 eminent authorities who contributed to it made every effort to include not only practical management measures but basic background material as well. Here in this thoroughly revised and up-dated fourth edition may be found the most recent concepts of metabolic care, and there are new chapters on Glycogen Storage Disease, Idiopathic Galactosemia, Protein Metabolism, Lipid Metabolism, Obesity, and Water Balance in Health and Disease. Handy charts of energy and vitamin requirements, normal growth patterns, height and weight standards, and special diets give valuable data at a glance. The book can be used profitably by almost any physician or specialist.

Nursing Home Management. By Ralph C. Williams, B.S., M.D., Margaret Bull Armstrong, R.N., J. Fred Gunter, B.B.A., Edith McCulloch, R.N., and Jack Stiller. Pp. 224. Illus. 75. Price, $8.50. New York, F. W. Dodge Corporation, 1959.

The problems of providing care and residence for the growing numbers of aged and chronically ill are treated with skill and compassion in this first handbook ever published on nursing home organization, management and operation. This carefully produced work outlines considerate, efficient standards that merit official and personal approval anywhere in the world. Whether the institution is intended primarily as a resident home for the elderly, or is more specifically geared to the treatment of disabilities and chronic diseases, its administrator will find the contents offering direct and practical help in his daily operations. Included is an enlightened discussion of the needs and problems of the elderly, and how to help them attain the satisfactions which are so vital to their well-being. Nursing home owners and administrators, nursing school instructors and students, federal and local health and welfare department personnel, charity groups and foundations, and registered nurses and others preparing to open nursing homes will find the book a valuable aid.

This handbook is the culmination of much of the experience of the authors, authorities in the fields of public health, medicine, nursing care and administration. They are: Ralph C. Williams, B.S., M.D., Director, Division of Hospital Services, State Department of Public Health, Atlanta, Ga.; Margaret Bull Armstrong, R.N., Director of Nursing Services, Thomas Memorial Hospital, South Charleston, W. Va.; J. Fred Gunter, B.B.A., Assistant Administrator, Kennestone Hospital, Marietta, Ga.; Edith McCulloch, R.N., now retired, formerly Director of Nurses at Kennestone Hospital, and Jack Stiller, Chief of Licensure, Division of Hospital Services, State Department of Public Health, Atlanta, Ga.

Hypertension. *The First Hahnemann Symposium on Hypertensive Disease.* Edited by John H. Moyer, M.D. Pp. 790. Price, $14.00. Philadelphia, W. B. Saunders Company, 1959.

An excellent summation of what is currently known about the origin, pathology, diagnosis and treatment of hypertension, this book embraces all the practical information to come out of the Symposium on Hypertension held at Hahnemann Medical College in December 1958. Ninety-one eminent clinicians, surgeons and researchers from this country and abroad relate what they have learned about the cause of hypertension and how effective therapeutic programs can be mapped out. Discussions are divided into these subject areas: Pathology and Clinical Aspects of Hypertension, Basic Concepts of Etiology of Hypertension, Pharmacology of Hypertension and Use of Sympathetic Blocking Agents, Role of Salt and Diuretics in the Therapy of Hypertension, Surgical Approach to Essential Hypertension, Effect of Therapy on Prognosis in Patients with Hypertension, and Summary: Today's Recommendations for Drug Therapy of Hypertension. All new drug agents, including chlorothiazide and its derivatives, other diuretics and ganglionic blocking agents, are fully evaluated. Indications for and results of surgical management are carefully explained. The book will provide internists and general physicians, in particular, with many valuable hints and helps to aid them in significantly improving their management of patients with hypertension.

(Continued on page 920)

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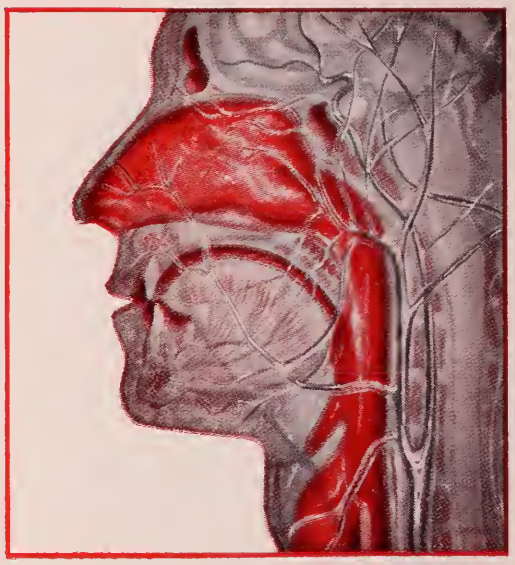
reaches all nasal and paranasal membranes *systemically*[1]



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- in nasal and paranasal congestion
- in sinusitis and postnasal drip
- in allergic reactions of the upper respiratory tract

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- presents no problem of rebound congestion
- avoids "nose drop addiction"

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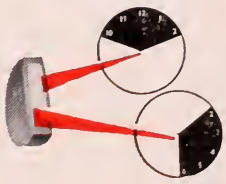

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then — the core disintegrates to give 3 to 4 *more* hours of relief

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Each timed-release Triaminic Juvelet® provides: ½ the formulation of the Triaminic Tablet.

Dosage: 1 Juvelet in the morning, midafternoon and at bedtime.

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Dosage (to be administered every 3 or 4 hours): *Adults* — 1 or 2 tsp.; *Children 6 to 12* — 1 tsp.; *Children 1 to 6* — ½ tsp.; *Children under 1* — ¼ tsp.

1. Fabricant, N. D.: E.E.N.T. Monthly *37*:460 (July) 1958.
2. Lhotka, F. M.: Illinois M. J.: *112*:259 (Dec.) 1957.
3. Farmer, D. F.: Clin. Med. *5*:1183 (Sept.) 1958.

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timed-release tablets and juvelets
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BIOLOGICALLY
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The impression that TAO is an unusually active antibiotic has steadily gained recognition by impressive clinical performance. Now come reports of **in vivo** and **in vitro** biological and biochemical evaluations that show TAO to be indeed unique.[1,2]

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Supplied: TAO Capsules—250 mg., and 125 mg., bottles of 60. **TAO for Oral Suspension**—125 mg. per tsp. (5 cc.) when reconstituted; unusually palatable cherry flavor; 60 cc. bottle. Prescription only.

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1. English, A. R., and McBride, T. J.: Proc. Soc. Exper. Biol. & Med. **100**:880 (Apr.) 1959. 2. Celmer, W. D.: Antibiotics Annual 1958-1959, New York, Medical Encyclopedia, Inc., 1959, p. 277. 3. English, A. R., and Fink, F. C.: Antibiotics & Chemother. 8:420 (Aug.) 1958.

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RELA—a new myogesic for better relaxant *and* analgesic therapy—more adept management of spasm and pain in strains, sprains and low back pains.

RELA—though a single drug—is a true myogesic and works rapidly to achieve three desired effects...

Rela relaxes acute muscle spasm
Relief of muscle spasm (96% excellent to good effectiveness)[1]

Rela provides a unique quality of persistent pain relief through its relaxant and analgesic actions
"Relief from pain was usually rapid and sometimes dramatic"[1]

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"... A number of patients reported freedom from insomnia which they attributed to freedom from pain."[1]

indications: RELA is most beneficial in those conditions of the musculoskeletal system manifesting pain, stiffness and spasm.

safety: Studies of more than 1400 patients indicate that the toxicity of RELA is exceptionally low. In human subjects, respiratory, blood pressure or blood chemistry changes and/or renal, hepatic or endocrine dysfunction have not been reported.

dosage: The usual adult dosage of RELA is one tablet 3 times daily and at bedtime. RELA has a rapid onset of action, with relief usually apparent within 30 minutes, and persisting for at least 6 hours.

supply: RELA is available as 350 mg., pink, coated tablets in bottles of 30.

1. Kuge, T. To be published.

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muscle relaxant analgesic

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The distinctive PREMIERE suite

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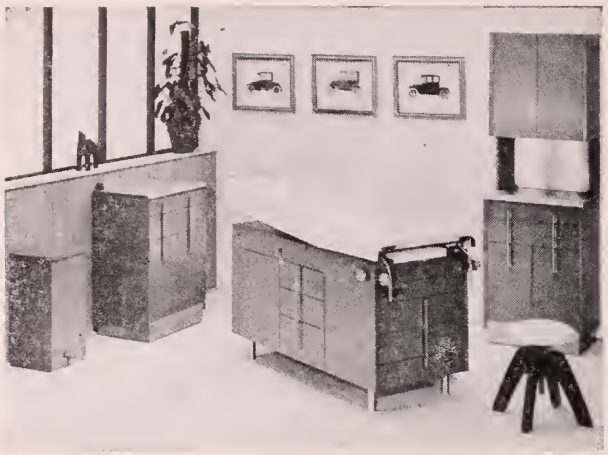

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muscle relaxant – analgesic

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The reasons are fairly simple. Doctors like "Premarin," in the first place, because it really relieves the symptoms of the menopause. It doesn't just mask them — it replaces what the patient lacks — natural estrogen. Furthermore, if the patient is suffering from headache, insomnia, and arthritic-like symptoms due to estrogen deficiency, "Premarin" takes care of that, too.

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SYMPOSIUM REPORT:

ALTAFUR in surgical (soft tissue) infections

In a series of 159 patients with various types of surgical infections (cellulitis, abscess, wound infections), ALTAFUR was employed with eminently satisfactory results. The incidence and magnitude of surgery were considerably reduced in these cases, and when surgical intervention was necessary it could be delayed until the inflammatory process had receded or become localized.

Excellent therapeutic response was obtained in patients with infections due to coagulase positive Staphylococcus aureus, beta hemolytic Streptococcus, and Escherichia coli; these organisms were uniformly susceptible to ALTAFUR in vitro. An insensitive strain of Pseudomonas aeruginosa was isolated from the single patient who failed to respond. ALTAFUR was given orally to 150 patients, the majority receiving 100 mg. four times daily.* Duration of treatment ranged from 4 to 30 days, averaged 6 days. An experimental intravenous preparation of ALTAFUR was administered to 9 patients who could not take medication by mouth or whose condition warranted exceptionally high dosage. There was no clinical or laboratory evidence of toxicity in any case, and ALTAFUR was well tolerated by all but 1 of the 159 patients.

Prigot, A.; Felix, A. J., and Mullins, S.: Paper presented at the Symposium on Antibacterial Therapy, Michigan and Wayne County Academies of General Practice, Detroit, September 12, 1959 (published Nov. 1959)

*Experimental dosage (see dosage recommendations adjacent)

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in systemic bacterial infections

- Antimicrobial range encompasses the majority of common infections seen in everyday office practice and in the hospital
- Decisive bactericidal action against staphylococci, streptococci, pneumococci, coliforms
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Miller, R. F.: Clin. Rev. 1:10 (July) 58

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safe and effective for patients of all ages suffering from respiratory tract congestion

DOSAGE

	TABLETS	SYRUP (5 cc. tsp.)	
Adults and older children	1	2	three times daily
Children 4 months to 6 years of age	½	1	
Infants through 3 months	–	½	

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(Continued from page 907)

Diseases of the Colon and Anorectum. By Robert Turell, M.D. Pp. 1296 in two volumes. Illustrations 974 on 634 figures. Price, $35.00 per set. Philadelphia, W. B. Saunders Company, 1959.

In this authoritative and practical presentation of successful diagnosis and treatment measures for the many diseases and disorders of the colon, rectum, and anus are delineated in explicit detail today's most effective management procedures. Dr. Turell has enlisted the aid of 82 distinguished teacher-specialists who present the technics that have proved most successful for them. Valuable background material is given first on anatomy, physiology and endocrine factors. Diagnosis is extensively covered. The various individual disorders are discussed with full information on all aspects of their management. Pathology, signs and symptoms, diets, drugs, indications for surgery, profusely illustrated step-by-step surgical technics, complications and radiotherapy are all described. Nearly 1,000 illustrations clarify difficult points of anatomy, pathology and surgical technics. For the surgeon, general practitioner and internist as well as for the proctologist, gastroenterologist and pediatrician this is a work of great usefulness and authority.

Patient Care and Special Procedures in X-Ray Technology. By Carol Hocking Vennes, R.N., B.S., and John C. Watson, R.T. Pp. 203. Price, $5.75. St. Louis, The C. V. Mosby Company, 1959.

The authors, who are associated with the training program in x-ray technology at the University of Minnesota, have written a textbook for x-ray technicians which defines the technician's role in the medical team caring for the sick and injured, supplies specific information on patient care in many diverse situations, and offers practical technical help for doing many special x-ray procedures. It is designed to be valuable in technician training programs, to serve as a reference on special procedures for the trained technician, and to be an aid to the nursing profession in better understanding the problems of x-ray technology as it relates to the patients.

The book doubtless will become an integral part of all well rounded teaching programs and should be a valuable addition to the thinking technician's reference library.

The Nature of Retirement. By Elon H. Moore, Ph.D. Pp. 217. Price, $4.50. New York, The Macmillan Company, 1959.

The reader of this book benefits from a rare union of viewpoints: the intellectual objectivity of an astute sociologist, and the compassionate subjectivity of a man of advanced years stepping into what he describes as "The Fourth State of Life." As a scholar and sociologist, the author bases his study of retirement on detailed questionnaires filled out by over 900 retired persons, as well as on close consultations with fellow social scientists in this important field and countless interviews with retired men and women throughout the country. Broad in scope and thorough and factual in content, the book also reflects the sympathies and affiliations of a man of retiring age. All who are interested personally or professionally in the problem of retirement will find this a practical, precise, sound and helpful approach to the subject.

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Resolutions for the New Year

Another New Year is here! It is the custom for many to stop and take stock of themselves at this time. It is also a custom for many to make "New Years' Resolutions," some of which are kept and many of which are broken. The Woman's Auxiliary is going to take stock of itself and perhaps make a few resolutions with the hope that none of them will be broken.

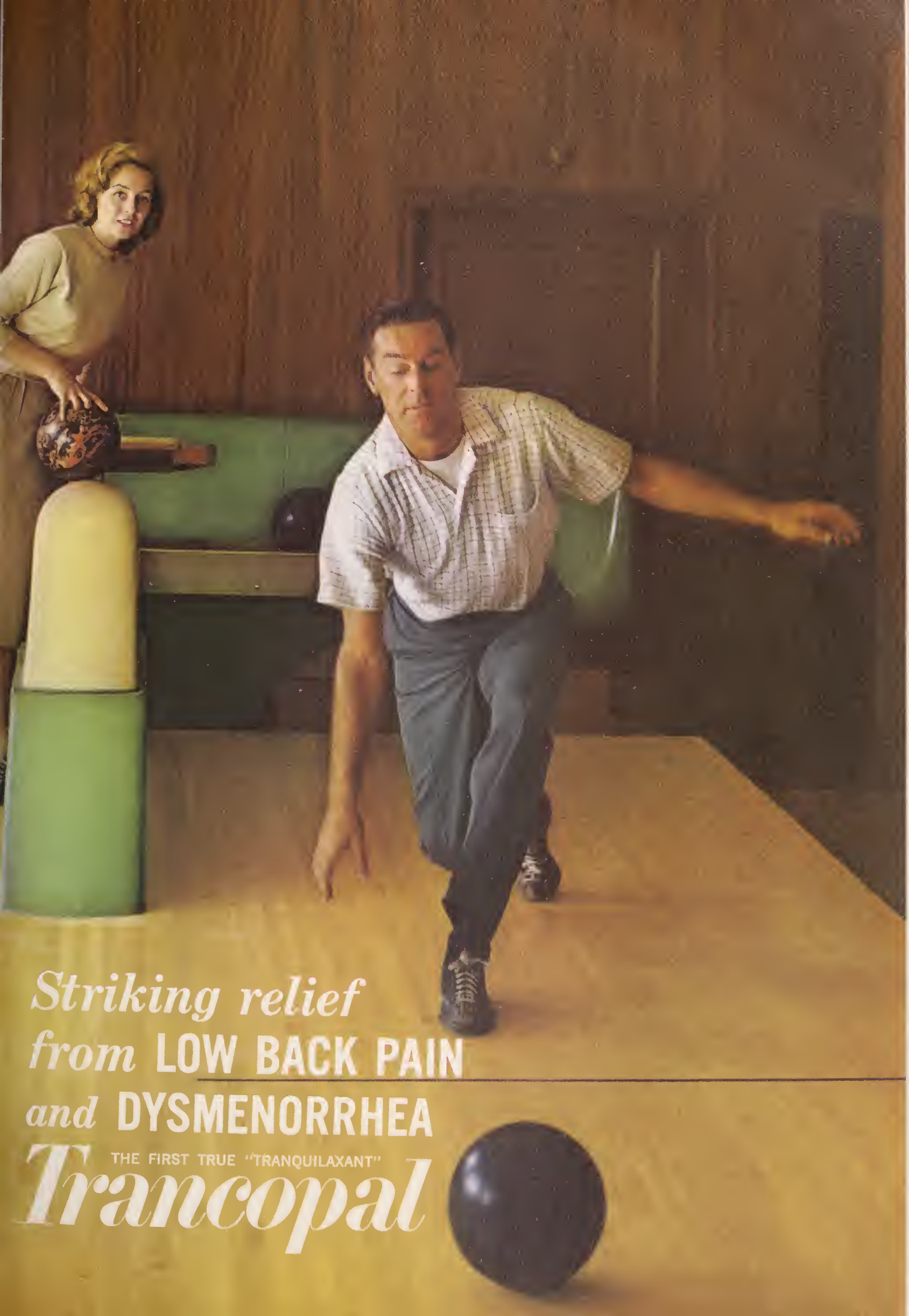
We are naturally very proud of our many accomplishments. In the past it has been our privilege to aid you in certain legislative difficulties which have arisen. We were delighted when Dr. Ralph Jack described the auxiliary as an additional weapon. We hope to be that additional weapon when you need our support and help in new legislative problems. That shall be our first "resolution," therefore, we will give you all the support we can, and will muster the "additional weapons."

In other years we have tried to respond to all your requests for help in various fields of endeavor. This year we have been asked by you to support the essays on Free American Enterprise. You will be pleased to note that the Board of the Woman's Auxiliary voted unanimously to sponsor these contests in high schools to the best of our ability. Our second resolution is to accept your requests for help with whole-hearted support.

These two resolutions cover a lot of territory. In return we ask only this of you. If you need something done that is within our power, ask us to do it. Look to the Woman's Auxiliary for your "additional weapons."

Mrs. Wendell J. Newcomb

The Annual Meeting of the Woman's Auxiliary to the Florida Medical Association will be held in Jacksonville at the time of the Annual Meeting of the Association on April 8-11. A complete program will be published in March.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THE FIRST TRUE "TRANQUILAXANT"
Trancopal

Here is what you can expect when you prescribe

for dysmenorrhea

and premenstrual tension

Case Profile*

A 28-year-old married woman, a secretary in a booking agency, complained of severe and consistent pain and cramps in the abdomen during her menstrual periods. Psychologically, she described the first two days as "climbing the walls." Menarche occurred at age 13. She has a regular twenty-eight day menstrual cycle and a four day menstrual period.

Trancopal was given in a dose of 100 mg. four times a day for the first two days of the four day period. In addition to the relief of the dysmenorrhea she also noticed disappearance of a "bloated feeling" that had previously annoyed her. She has now been treated with Trancopal for one and one-half years with excellent results. Other medication, such as codeine or aspirin with codeine, had relieved the pain, but the patient had had to stay home. Because her father is a physician, many commercial preparations had been tried prior to Trancopal, but no success had been achieved.

Before taking Trancopal this patient missed one day of work every month. For the past year and a half she has not missed a day because of dysmenorrhea.

THE FIRST TRUE "TRANQUILAXANT"

Trancopal®

for low back pain

Case Profile*

A 42-year-old truck driver and mover injured his back while moving a piano. The pain radiated from the sacral region down to the region of the Achilles tendon on the right side. X-rays for ruptured disc revealed nothing pertinent. The day of the injury he was given Trancopal immediately after the physical examination. Although 100 to 200 mg. three times a day were prescribed, the patient on his own responsibility increased the dosage of Trancopal to 400 mg. three times a day. This dosage was continued for three days and then gradually reduced over a ten day period. During this time, the patient continued to drive his truck. The muscle spasm was completely controlled and no apparent side effects were noted.

For the past six months, the patient has continued to take Trancopal 100 to 200 mg. as needed for muscle spasm, particularly during strenuous days.

**Clinical Reports on file at the Department of Medical Research, Winthrop Laboratories.*

Turn page for complete listings of Indications and Dosage.

THE FIRST TRUE "TRANQUILAXANT"

Trancopal

potent MUSCLE RELAXANT

effective TRANQUILIZER

- In musculoskeletal disorders, effective in 91 per cent of patients.[1]
- In anxiety and tension states, effective in 89 per cent of patients.[1]
- Low incidence of side effects (2.3 per cent of patients). Blood pressure, pulse rate, respiration and digestive processes are unaffected by therapeutic dosage. It does not affect the hematopoietic system or liver and kidney function.
- No gastric irritation. Can be taken before meals.
- No clouding of consciousness, no euphoria or depression.

Indications [1-6]

Musculoskeletal:

Low back pain (lumbago, etc.)
Neck pain (torticollis)
Bursitis
Rheumatoid arthritis
Osteoarthritis
Disc syndrome
Fibrositis
Ankle sprain, tennis elbow
Myositis
Postoperative muscle spasm

Psychogenic:

Anxiety and tension states
Dysmenorrhea
Premenstrual tension
Asthma
Angina pectoris
Alcoholism

Now available in two strengths:

Trancopal Caplets®,
100 mg. (peach colored, scored), bottles of 100.

NEW STRENGTH ▶ Trancopal Caplets,
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Dosage: Adults, 100 or 200 mg. orally three or four times daily. Relief of symptoms occurs in from fifteen to thirty minutes and lasts from four to six hours.

Winthrop LABORATORIES
New York 18, N. Y.

References: 1. Collective Study, Department of Medical Research, Winthrop Laboratories. 2. Lichtman, A. L.: New developments in muscle relaxant therapy, *Kentucky Acad. Gen. Pract. J.* 4:28, Oct., 1958. 3. Lichtman, A. L.: Relief of muscle spasm with a new central muscle relaxant, chlormezanone (Trancopal), Scientific Exhibit, Meeting of the International College of Surgeons, Miami Beach, Fla., Jan. 4-7, 1959. 4. Ganz, S. E.: Clinical evaluation of a new muscle relaxant (chlormethazanone), *J. Indiana M. A.* 52:1134, July, 1959. 5. Mullin, W. G., and Epifano, Leonard: Chlormezanone, a tranquilizing agent with potent skeletal muscle relaxant properties, *Am. Pract. Digest Treat.* 10:1743, Oct., 1959. 6. Shanaphy, J. F.: Chlormezanone (Trancopal) in the treatment of dysmenorrhea; a preliminary report, *Current Therap. Res.* 1:59, Oct., 1959.

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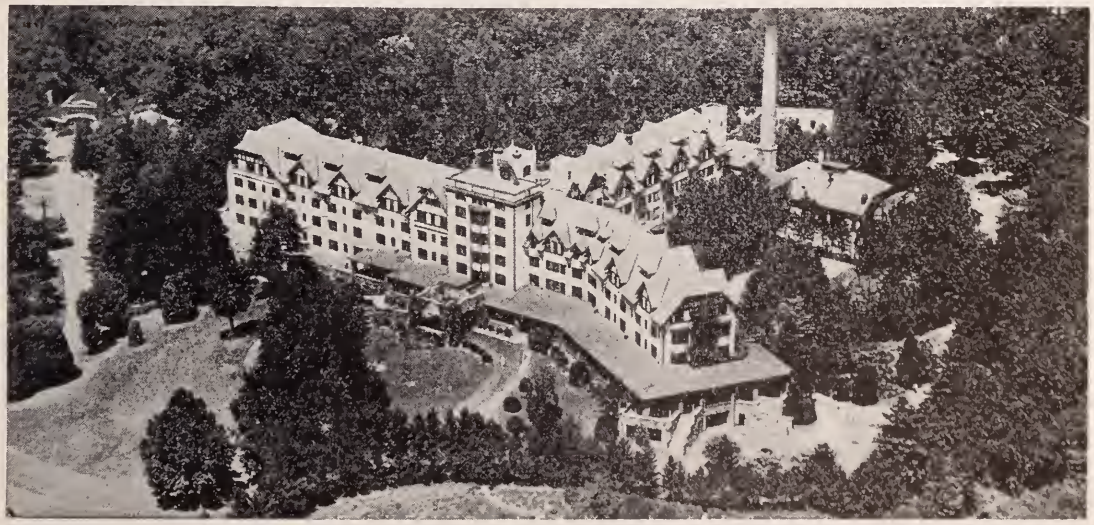

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			" " " "
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n Medical Association	Louis M. Orr, Orlando	F. J. L. Blasingame, Chicago	Miami Beach, June 13-17, '60
A. Clinical Session			Wash., D. C., Nov. 29-Dec. 2, '60
n Medical Association	Milford O. Rouse, Dallas, Texas	V. O. Foster, Birmingham	
a Medical Association	William R. Carter, Repton, Ala.	Douglas L. Cannon, Montgomery	Mobile, Ala., April 21-23, '60
Medical Assn. of	Luther H. Wolff, Columbus, Ga.	Chris J. McLoughlin, Atlanta	Columbus, Ga., May 1-4, '60
ap. Arthritis & Rheuma-foundation	John P. Mozur, Miami	J. Charles McKee Jr., Miami	
ospital Conference	Oscar S. Hilliard, Ft. Oglethorpe, Ga.	Glenn Hogan, Atlanta	Miami Beach, May 3-7, '60
m. Urological Assn.	Lawrence Thackston, Or'burg, S.C.	S. L. Campbell, Orlando	Jcks'ville, March 13-16, '60
stern Allergy Assn.	C. P. Wofford, Johnson City, Tenn	Kath. B. MacInnis, Columbia, S.C.	
stern Surgical Congress	M. M. Copeland, Washington, D.C.	B. T. Beasley, Atlanta	N. Orleans, March 21-24, '60

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Bay	James D. Nixon, Panama City	Robert L. Overman, Panama City	2nd Tues.	34
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Broward	Anthony C. Galluccio, Hollywood	Frederick W. Fisher, Ft. Lauderdale	4th Tues.	258
Charlotte	Robert H. Shedd, Punta Gorda	Carl N. Reilly, Punta Gorda	2nd Tues.	6
Collier	Loral F. Gwaltney, Naples	Ethel H. Trygstad, Naples	4th Tues.	13
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** Baker*				
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DeSoto-Hardee-Glades	Harold S. Agnew, Arcadia	Elmer J. Schmierer, Arcadia	1st Tues.	26
Duval	Floyd K. Hurt, Jacksonville	Albert D. Rood, Jacksonville	1st Tues.	358
** Clay*				
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Source: Traisman, H. S.; Boehm, J. J., and Newcomb, A. L.: Diabetes *8*:289, 1959.

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Order of Frequency of Presenting Symptoms in 110 Patients

Symptoms	No. of Patients	Per cent of total group
Polyuria	93	84.5
Polydipsia	89	81.0
Weight loss	47	42.7
Polyphagia	28	25.4
Anorexia	16	14.5
Lethargy	14	12.7
Enuresis	7	6.4
Vomiting	5	4.5
Irritability	3	2.7
"Craving for sweets"	3	2.7
"Sticky diaper"	3	2.7
"Strong odor to urine"	2	1.8
Glycosuria	2	1.8
Hypoglycemia	2	1.8
Personality change	1	0.9
Boils	1	0.9
Headache	1	0.9
Abdominal cramps	1	0.9

Adapted from Traisman, H. S.; Boehm, J. J., and Newcomb, A. L.*

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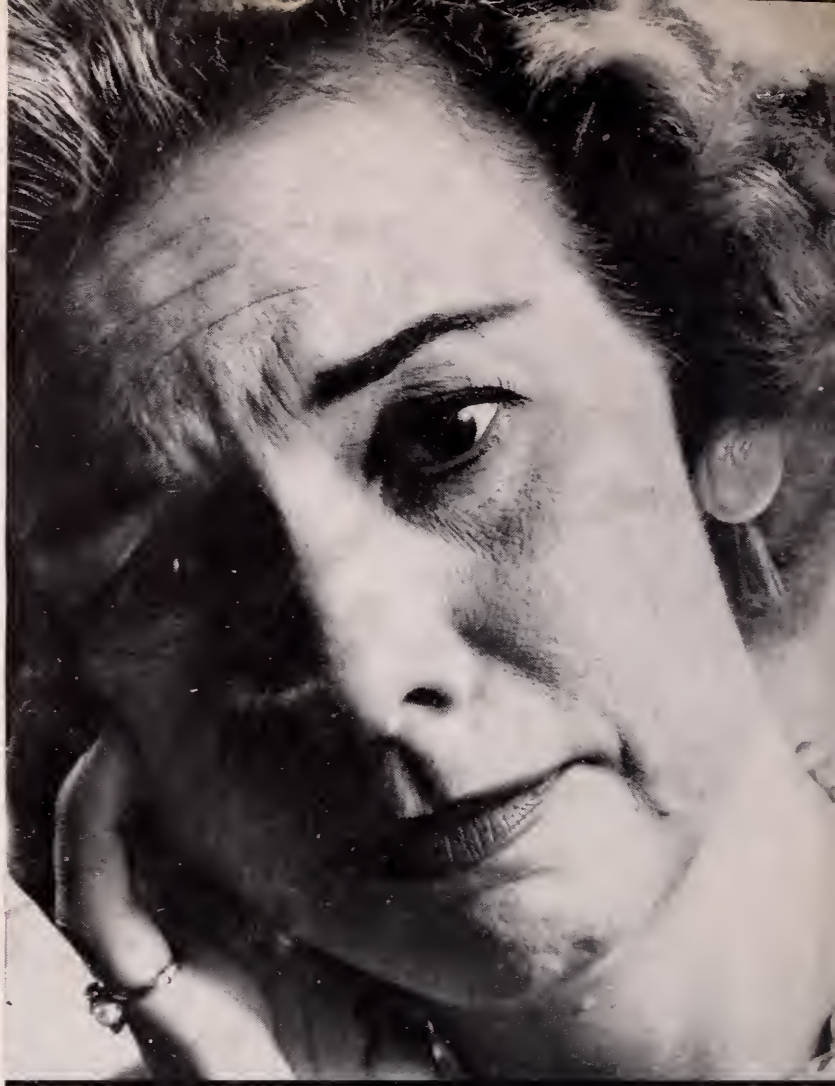

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CHLOROMYCETIN is a potent therapeutic agent and, because certain blood dyscrasias have been associated with its administration, it should not be used indiscriminately or for minor infections. Furthermore, as with certain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy

CHLOROMYCETIN

(chloramphenicol, Parke-Davi

PROVES OUTSTANDINGLY EFFECTIVE AGAINST PROBLEM PATHOGEN

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REFERENCES: (1) Leming, B. H., Jr., & Flanigan, C., Jr., in Welch, H., & Marti-Ibānez, F.: Antibiotics Annual 1958-1959, New York, Medical Encyclopedia, Inc., 1959, p. 414. (2) Goslings, W. R. O., & Buchli, K.: *Arch. Int. Med.* 102:691, 1958. (3) Suter, L. S., & Ulrich, E. W.: *Antibiotics & Chemother.* 9:38, 1959. (4) Metzger, W. I., in Welch, H., & Marti-Ibānez, F.: Antibiotics Annual 1958-1959, New York, Medical Encyclopedia, Inc., 1959, p. 966. (5) Fischer, H. G.: *Deutsche med. Wchnschr.* 84:257, 1959. (6) Borchardt, K. A.: *Antibiotics & Chemother.* 8:564, 1958. (7) Schneierson, S. S.: *J. Mt. Sinai Hosp. New York* 25:52, 1958. (8) Waisbren, B. A.: *Wisconsin M. J.* 57:89, 1958.

*Adapted from Leming & Flanigan.[1]

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VOLUME XLVI, No. 8

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This Journal is not responsible for the opinions and statements of its contributors.
Owned and published by Florida Medical Association.

Published monthly at Jacksonville, Florida. Price $5.00 a year: single numbers, 50 cents. Address Journal of Florida Medical Association, P.O. Box 2411, 735 Riverside Ave., Jacksonville 3, Fla. Telephone EL 6-1571. Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918. Entered as second-class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida, October 23, 1924.

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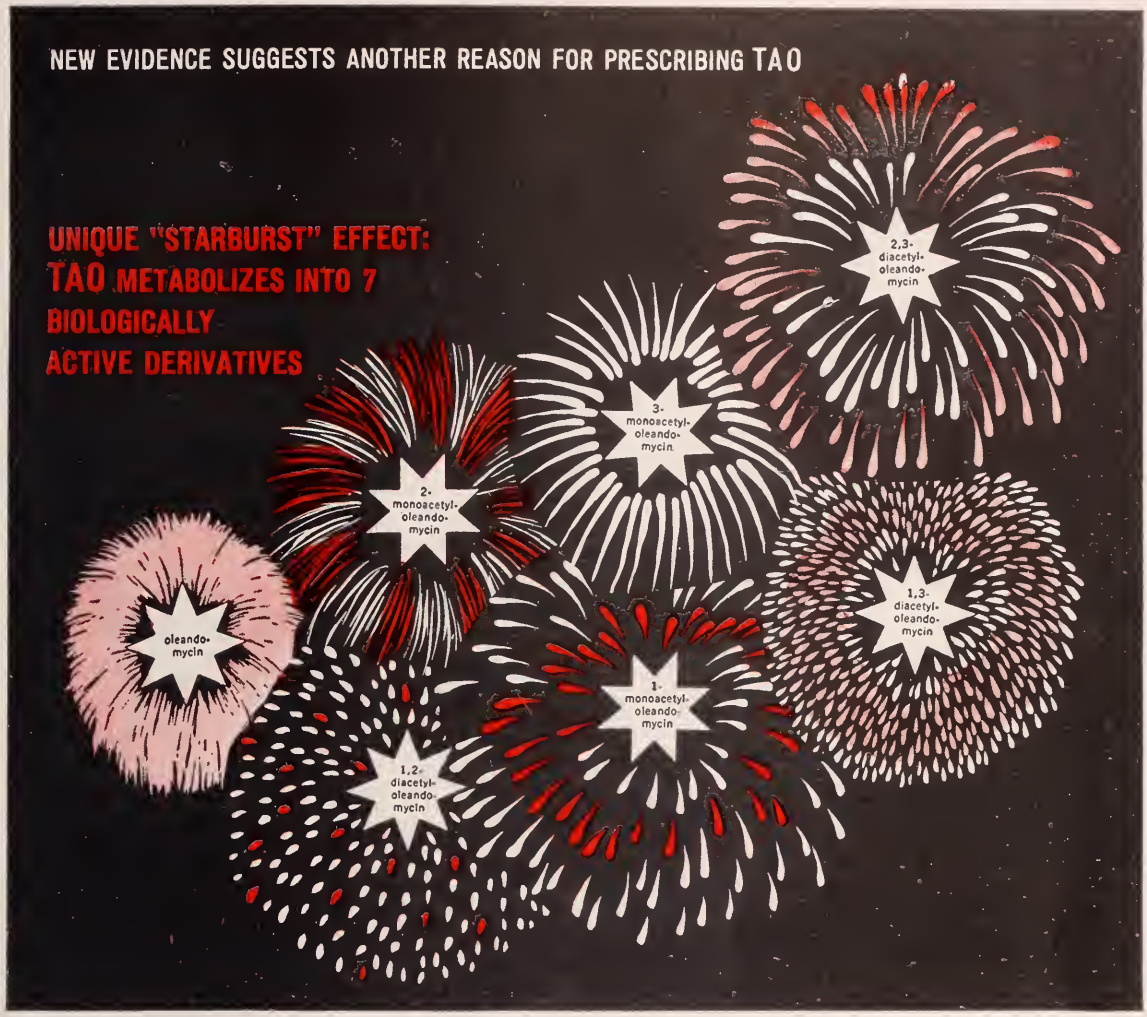

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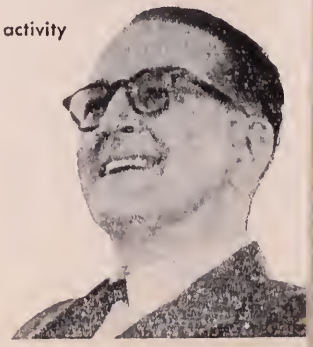

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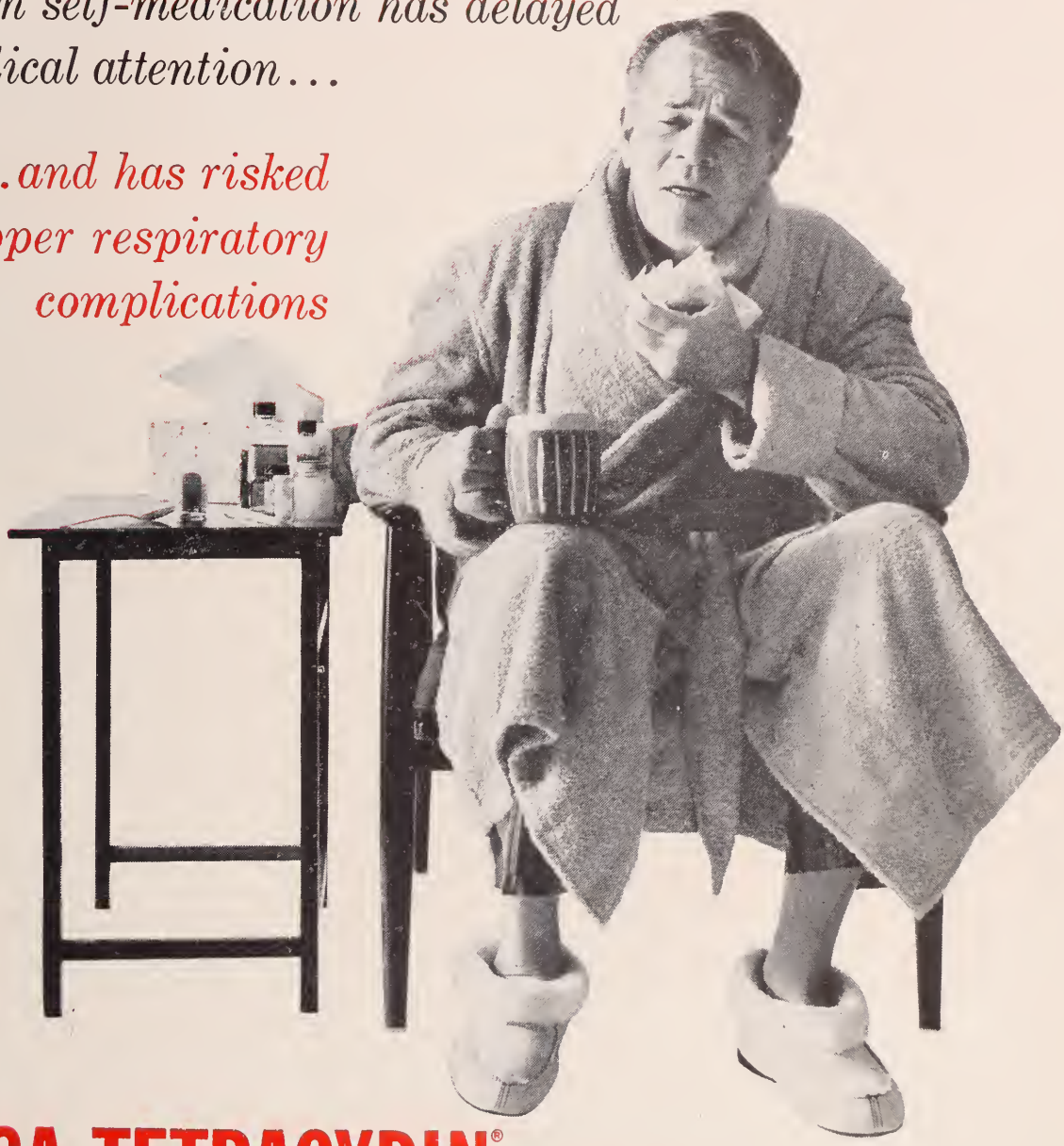

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true "tranquilaxant"
keeps the patient
on the job

THE FIRST TRUE "TRANQUILAXANT"

Trancopal®

relieves painful muscle spasm and relaxes the patient

Impressive numbers of patients with low back pain and other musculospastic conditions treated with Trancopal have been freed of symptoms and enabled to return to their usual activities, according to newly published clinical reports. In a recent study by Lichtman,[1] Trancopal broug excellent to satisfactory muscle relaxation t 817 of 879 patients. The patients in this group suffered from skeletal muscle spasm associated with low back pain (361 cases), stiff neck (128 cases), bursitis (177 cases), and other skeletal muscle disorders (213 cases). Side effects were rare (2 per cent of patients), and it was not necessary to discontinue medication in any of the patients. Lichtman comments: "Chlormethazanone [Trancopal] not only relieved painful muscle spasm, but allowed the patients to resume their normal activities with no interference in performar of either manual or intellectual tasks."[2]

When you prescribe Trancopal for musculoskeletal disorders, you can confidently expect that your patients will be relieved of the pain and stiffness. You can be sur of their speedy return to everyday work and recreation.

ullin and Epifano call Trancopal "...a very effective skeletal muscle spasmolytic."[3] hey found that Trancopal brought good to excellent relief to all of 39 patients with keletal muscle spasm related to trauma, bursitis, rheumatoid arthritis, osteoarthritis, and itervertebral disc syndrome. (No side effects were noted except that one patient had slight yness of the mouth.)

he pattern is similar in every new series reported: Ganz,[4] DeNyse,[5] Shanaphy[6] and Stough.[7]

rancopal is a true "tranquilaxant"

rancopal "...combines the properties of tranquilization and skeletal muscle relaxation ith no concomitant change in normal consciousness."[6]

elieves dysmenorrhea

Trancopal not only is valuable in treating patients with low back pain and other musculoskeletal disorders, but is also very effective in bringing relief from menstrual cramps and discomfort. Shanaphy suggests that Trancopal may help the patient by its combination of muscle relaxant and tranquilizing actions, and he finds that "...the continued use of chlormezanone [Trancopal] as a therapeutic agent in dysmenorrhea is advisable."[6] Trancopal was effective in 82 per cent of his series of 50 patients. In another study, which dealt with 52 adolescent girls and 23 women, Stough[7] reported that Trancopal gave complete or moderate relief in 86.4 per cent.

lleviates tension

nd, of course, Trancopal is also very useful in the treatment of patients in anxiety nd tension states. As Ganz says, "...a most valuable drug for relieving tension, prehension and various psychogenic states...allows the patient to use his energies in more productive manner in overcoming his basic problems."[4]

Trancopal

a true "tranquilaxant"

that relieves skeletal muscle spasm and relaxes psychogenic tension without troublesome side effects, and keeps the patient on the job.

Indicated for...

Musculoskeletal disorders		Psychogenic disorders
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Neck pain (torticollis)	Ankle sprain, tennis elbow	Dysmenorrhea
Bursitis	Myositis	Premenstrual tension
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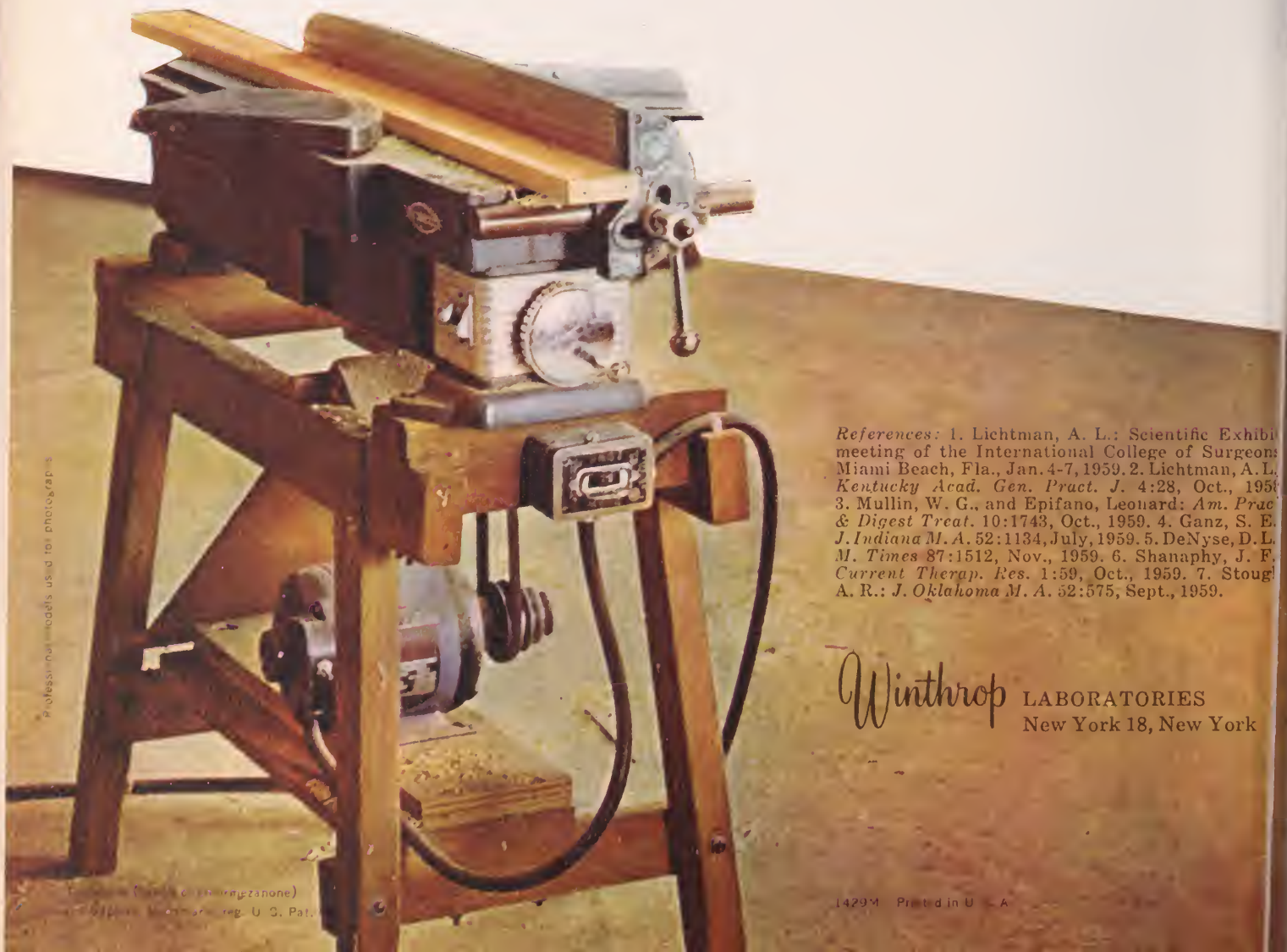

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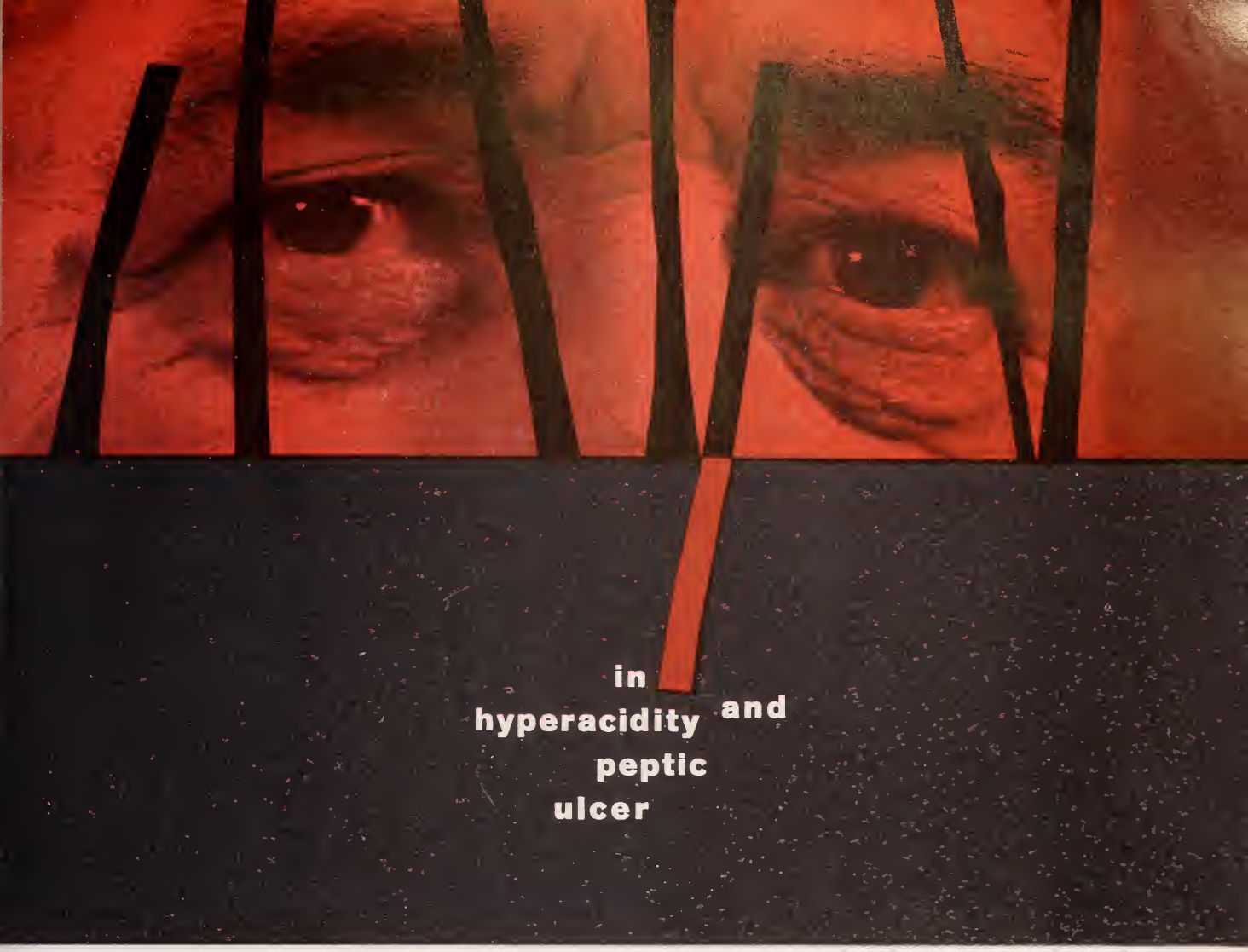

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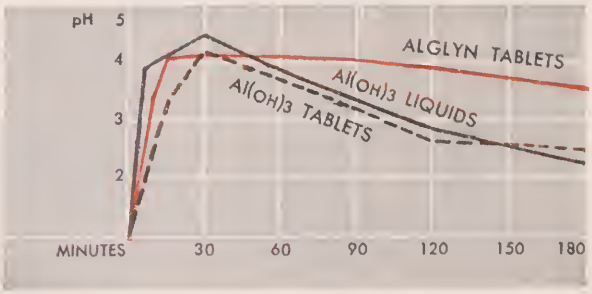

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You see an improvement within a few days
Thanks to your prompt treatment and the quick, smooth action of Deprol, her depression is relieved and her anxiety and tension calmed – *often in a few days.* She eats well, sleeps well and soon returns to her normal activities.

as it calms anxiety!

Smooth, balanced action lifts depression as it calms anxiety... swiftly and safely

Balances the mood — no "seesaw" effect of amphetamine-barbiturates and energizers. While amphetamines and energizers may stimulate the patient — *they often aggravate anxiety and tension.* And although amphetamine-barbiturate combinations may counteract excessive stimulation — *they often deepen depression.*

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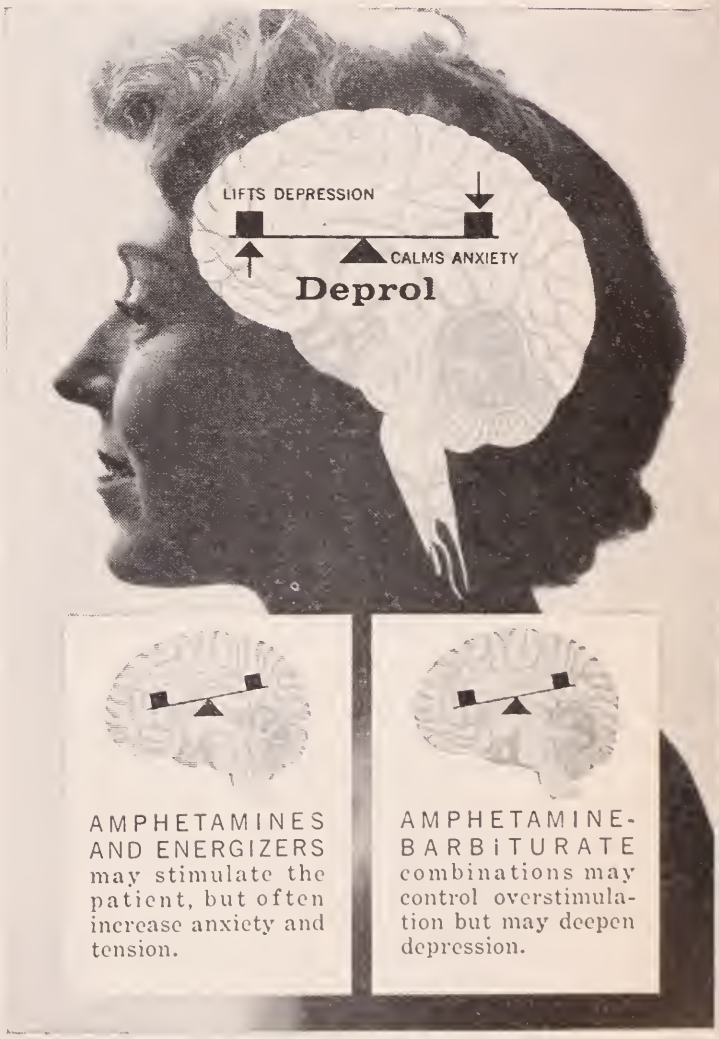
Acts swiftly — the patient often feels better within a few days. Unlike the delayed action of other drugs which may take two to six weeks to bring results, Deprol's smooth, immediate action relieves the patient quickly — often within a few days.

Acts safely — no danger of liver damage. Deprol does not produce liver damage, hypotension, psychotic reactions or changes in sexual function — frequently reported with other drugs.



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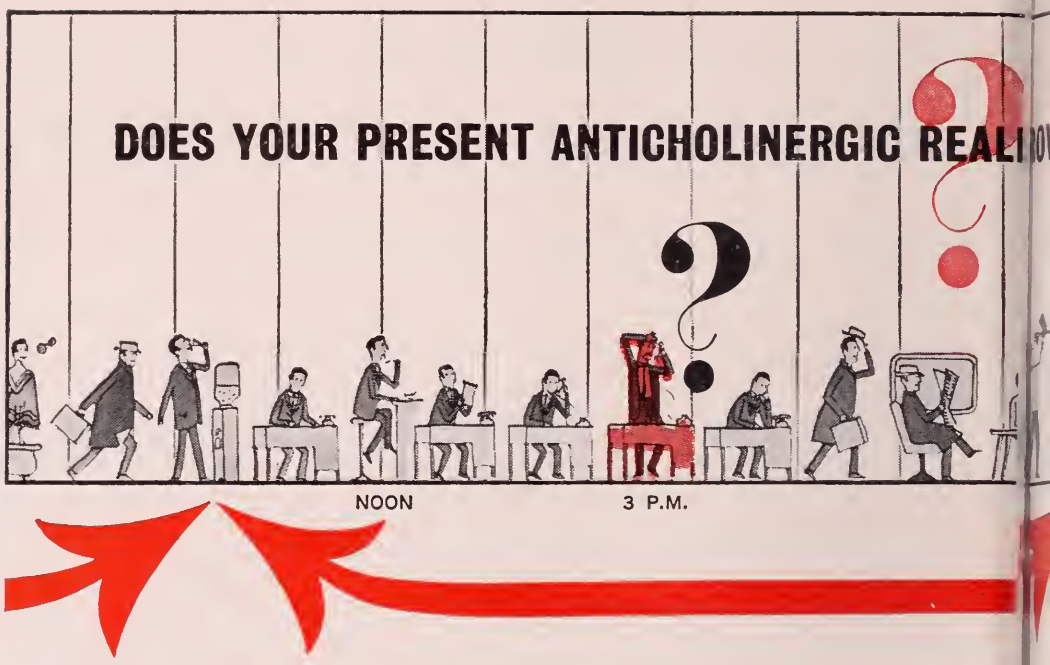

The test—you might say the acid test—of an anticholinergic is simple: will it protect your patient from hyperacidity around the clock, **even while he sleeps.** The weakness of t.i.d. or q.i.d. preparations is well recognized; but even some "b.i.d." encapsulations may be unreliable. McHardy, for instance, found a "widely variable duration of action, definitely less than that anticipated" in the "sustained," "delayed," and "gradual release" anticholinergics he studied.[1]

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OBSERVE THE OXYPHENCYCLIMINE REPORTS . . .

McHardy: "[Oxyphencyclimine] has proved to be an excellent sustained-action anticholinergic in our study of this agent over a period of eighteen months."[1]

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Add Atarax to this 12-hour anticholinergic. The resulting combination—ENARAX—now gives relief from emotional stress, in addition to a reduction of spasm and acid. Atarax does not stimulate gastric secretion. No serious adverse clinical reaction has ever been documented with Atarax.

LOOK AT THE RESULTS WITH ENARAX[4,5]:

Does the medication you now prescribe assure you of all these benefits? If not, why not put your next patient with peptic ulcer or G.I. dysfunction on therapy that **does.**

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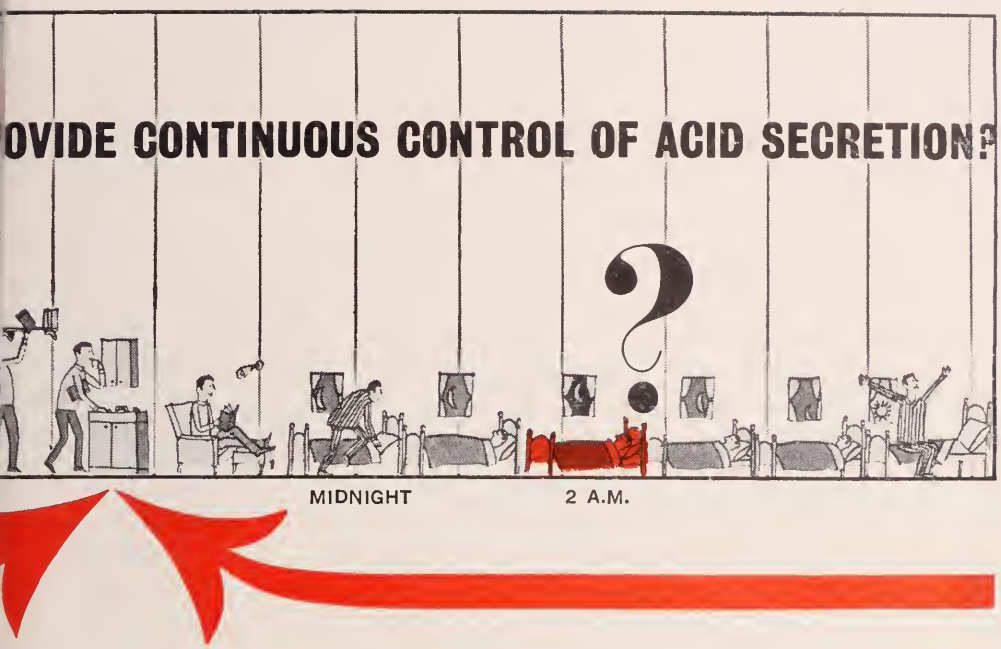

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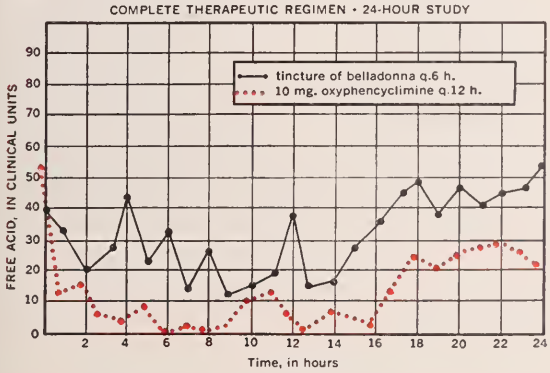

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References: 1. McHardy, G., et al.: J. Louisiana M. Soc. 111:290 (Aug.) 1959. 2. Steigmann, F.: Study conducted at Cook County Hospital, Chicago, Illinois, in press. 3. Kemp, J. A.: Antibiotic Med. & Clin. Therapy 6:534 (Sept.) 1959. 4. Leming, B. H., Jr.: Clin. Med. 6:423 (Mar.) 1959. 5. Data in Roerig Medical Department files.

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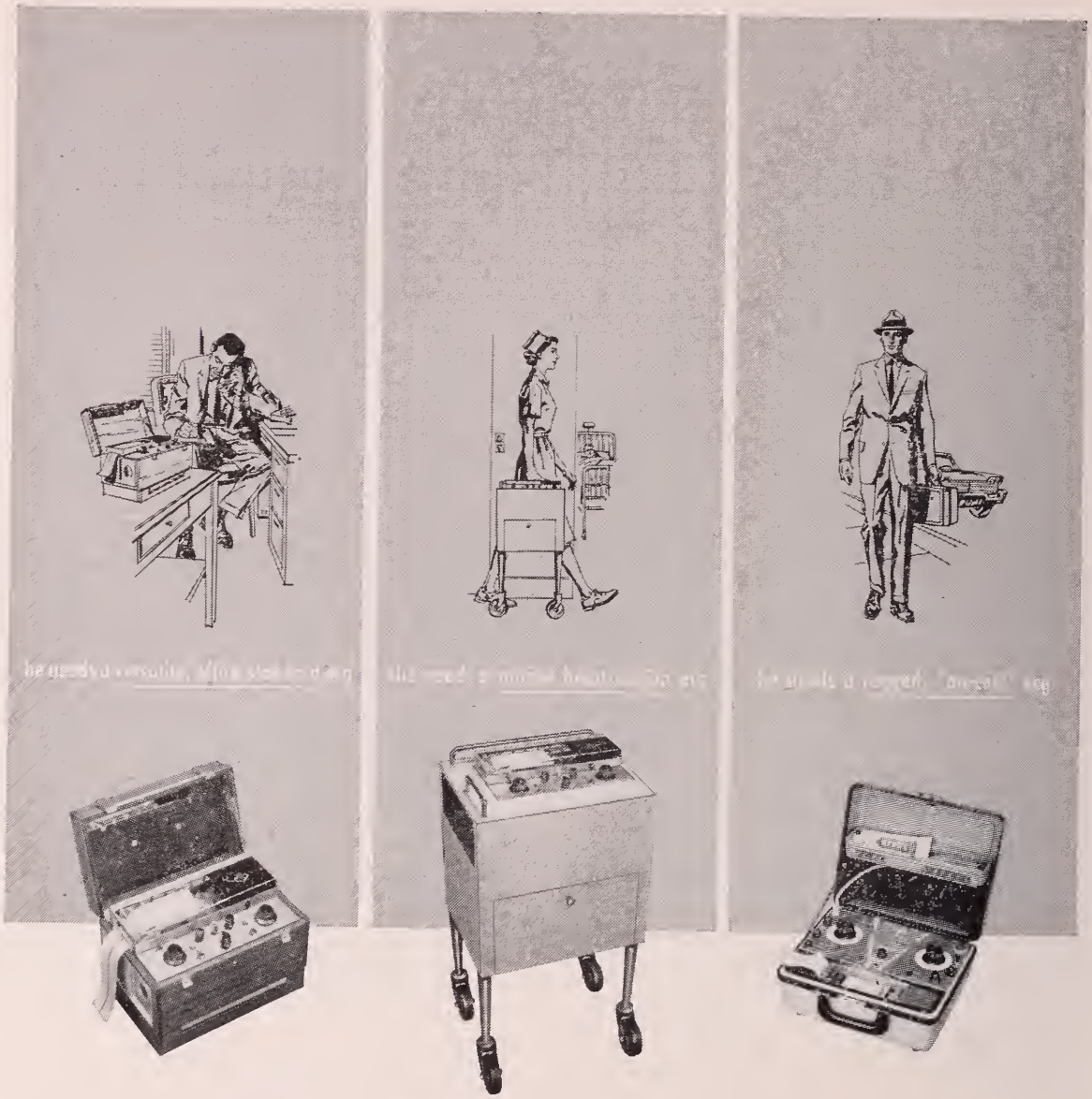

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1. Smith, I. M., and Soderstrom, W. H.: J. A. M. A., *170*:184 (May 9), 1959.

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THE JOURNAL
OF THE
FLORIDA MEDICAL ASSOCIATION

Volume XLVI, No. 8, February, 1960

Doctors' Dilemmas

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M.R.C.S. (ENGLAND); L.R.C.P. (LONDON)
BOSTON

Let us look at things as they really are!

First, the Pharmaceutical Manufacturers' Association reported that during 1958 its members had tested 114,600 therapeutic substances of which 1,900 had reached the stage of clinical investigation. Thirty absolutely new products were placed on the market. Each represented an average investment of $6,000,000.

Second, the American Druggist reported that during 1958, the number of prescriptions written for that year totaled 584,000,000. For these, the patients paid, at retail cost, $1,790,000,000.

Third, an examination of the prescriptions written showed that 90 per cent were for drugs which, as of 1943, had not as yet been invented.

In other words, excepting for the 10 per cent of "old drugs" prescribed, physicians apparently like to use new drugs. And, many more such new drugs or formulations of them are being prepared to help us practice better medicine.

Progress Versus Time Lag

But, there are problems involved. It takes a minimum of five years of clinical use for almost all of the important specific, nonspecific, and toxic effects of a drug to become known. If this be true, then any physician whose formal training ended only five years ago will prescribe drugs which had not been invented while he was either in medical school, or during his internship or residency. Think of what this part of the problem represents for the physician who first went into practice 10, 15, or 20 years ago! He can know no more about these new drugs than circumstances of use have forced him to learn. Where is the information he needs available, and how up-to-date is it?

I can give you one example. At my laboratory, we have intermittently, but for almost 25 years, worked on the problem of the treatment of hay fever with single annual injections of emulsified extract of pollen. The first papers published, by others, in this field appeared as early as 1923. There were subsequent papers, but in specialty journals published 20 years ago. For all the noise they made, you would have thought that a rose petal had been dropped, and quietly at that, into the Grand Canyon. Yet, having used pollen extract with pollen oil diluted in mineral oil since 1938, I thought that all of these papers represented common knowledge. One of the first papers I wrote on the use of the emulsified extracts as prepared today described methods of preventing possible systemic reactions, should allergists use such emulsions as might not be complete, that is, contain unemulsified pollen extract, in excess of what the patient might safely tolerate. I possessed no means of learning how much my colleagues knew.

The important point to make and I hope, worth making, is the history of one special study. The groundwork for the emulsion used was laid down three years ago. The 685 patients were treated during the ragweed pollen season of 1958. The paper will appear sometime late in 1959. By the time you read it, either in a specialty journal, or secondarily in an abstracting review, practically

Read before the Florida Medical Association, Eighty-Fifth Annual Meeting, Bal Harbour, Miami Beach, May 4, 1959.

everything it describes will be out of date. The extract described is no longer in use. Neither is the method of "pretreating" patients to prevent systemic reactions. The reactions it mentions do not occur. The emulsion is made and tested by other means than those listed. As regards this one subject, the most up-to-date allergist who studies the Annals of Allergy the day it reaches him will read papers presented up to one year ago. In other words, in my own present practice, we have gone beyond the papers in press. The studies, the techniques, and the results achieved today will appear in print at the earliest, during 1960, and at the latest, during 1961. Some of the long range studies are scheduled for publication in 1964.

This problem is no different from that seen in a dozen other fields, and especially in that concerned with communication as regards reactions to drugs. The basic dilemma is no different. The reaction your patient experienced may have been described, but you may not have read of it. A description of it may be in press, in which case you must wait until it appears in print, and then hope that the paper itself or reference to it somehow passes before your eyes. The Cumulative Index Medicus will not help you, because it is at least two years out of date. Unless you see the Current List of Medical Literature, or Current Contents, you are practicing medicine as of the year before last.

The point can be pressed home with another example. During 1952 and 1953, Welch and his colleagues spot-checked 11 cities with populations of 100,000 or more. They uncovered 84 cases of anaphylactic shock caused by the administration of penicillin. Of these, 25 were fatal. But, not one of these penicillin-caused deaths has been reported in the literature. You could, therefore, not at that time learn what the true reaction rate might be.

A similar survey of a number of hospitals, possessing in all almost 200,000 beds and used by a population of which the number is not known, was made five years later. There were 3,500 reactions to antibiotic agents. Of the 2,995 documented case histories suitable for tabulation purposes, 2,517 represented those in which penicillin had been used. The fatality rate of the group of anaphylactic reactions, independently as to whether they were caused by the first or by the hundredth injection of penicillin, was 9 per cent. This report was made available to every physician in the United States. I wonder how many read it.

Should you do investigative work, you can get to use a drug or a technique up to two or three years ahead of its reports. Attendance at a state or a specialty society annual meeting can advance your practice by more than one year. Keep up with the literature, and, for communications not given at meetings, you are perhaps only six to 12 months out of date. In all instances, as regards drugs, you will learn only of the reported reactions. The books which represent entombed knowledge for reference purposes only are out of date the day they appear.

Advances in Therapeutics

A textbook on Pharmacology you may have studied 20 years ago resembles one recently published only in its name. The older book lists the properties of many drugs which, in their own day, were seldom prescribed. There are lengthy discussions of the actions of strychnine, arsenic, bismuth, iodides, and mercury. Many of these and other drugs were then used, as part of "supportive therapy." This elegant phrase means no more than that the patient was kept comfortable and no harm was wittingly done him while he, of himself, recovered from his illness, or despite your efforts, died.

To illustrate some of the advances in therapeutics, the older book lists no antibiotic, antiarthritic, anticonvulsant, or anorexiant agent, and none of the new antimalarial compounds, no ataractic drugs, and certainly no psychic energizers. It mentions no hypotensor drugs, no corticosteroid hormones, and no oral hypoglycemic agents. There are no discussions of thyroid function depressants. The radioisotopes had not been invented. To go back to 25 years ago leads to the painful discovery that none of the vitamins are listed, and that the existence of only one was suspected.

The drugs of today are often specific, but, in a special sense, are also multipurpose, as are the antihistaminic agents which, to list only a few of their properties, may be antiallergic, antiemetic, or tranquilizing. The corticosteroid hormones are not only antiallergic and anti-inflammatory, but useful in more than 50 categories of disorders for which there existed no previous treatment whatsoever.

The Dilemma of Drug Idiosyncrasy

The physician of 20 years ago had little difficulty in recognizing an untoward reaction, as for example, an iododerma. Then, there was no specific

treatment. The more distant reactions of today's drugs are not always easily recognizable; yet when recognized, they can be treated easily and often with success. Although the drugs of today cause more types of reactions, and those more frequently, we possess many more drugs for the treatment of such reactions. I am not sure that we are ahead.

For example, a reaction to penicillin, when acute, will often respond and immediately to an injection of epinephrine. Then, the injection of penicillinase will prevent further reaction. The administration of the corticosteroid hormones will reverse the reactions present. But the picture is not that pretty.

Supposing a sick patient suffering from heart block is afflicted with an infection, and then reacts adversely to penicillin, and you are hesitant to use epinephrine, but as the reaction permits, you inject penicillinase. Should the patient react equally adversely to the penicillinase, he may be in real difficulties. How would you like to treat snake bite in a leg that is affected not only with a poison ivy dermatitis, and also with a severe erythema solare, but in addition, is broken?

When we do not take the time to ask the necessary questions, or to warn our patients, then we can, whenever we choose, see classic examples of intolerance, as when we prescribe iodides or salicylates. These do not represent dilemmas, but problems of proper practice.

The dilemma of idiosyncrasy puzzles the best of us until we learn that, in some patients there may be, of many others, two special types of responses. The first is paradoxical as when sedatives excite or the ataractic and euphoriant drugs depress our patients. There is no test excepting, in all patients, to prescribe a small initial dose. If the patient is a placebo reactor, you are ahead of the game. When the drug causes no reaction or acts as it should, but not sufficiently so, you can safely prescribe more. Less often recognized is a second paradoxical effect. The greater the degree of abnormality present, the more likely it is that the drug will, in ordinary doses, be without effect, and then with larger doses, bring on an extreme opposite effect. In some patients, for example, the higher the hypertension, the more difficult it is to bring the pressure down without having the patient become hypotensive.

Distant or delayed side effects continue to represent one of our major problems. That jaundice may follow the administration of chlorpromazine is generally known, but its prevention, in most patients, by the prescription of additional fluid intake, is not. Prolonged ingestion of iodides (and, by the way, cobalt) may result in goiter. The topical use of resorcin may, however, induce myxedema. An anticonvulsant, phenytoin, will, if used for periods of five to 10 years, affect folic acid metabolism. A megaloblastic anemia will develop. Other anticonvulsant drugs may cause the appearance of what resembles a malignant lymphoma. The use of para-aminosalicylic acid may result in a disorder resembling mononucleosis. These are not common, but think of the patient's clinical course, should they not be recognized!

The drug manufacturer may enclose literature with the original package, but this of course stands on the pharmacist's shelf. We hardly ever see the enclosure, and the fine print is, in any case, often beyond the resolution point of our bifocals. On the label of an injectable drug which we handle may be printed, in larger letters, "literature is available on request." Few of us possess either the opportunity or the facilities for writing for it. The manufacturer does his best to supplement these two methods of imparting information by mailing to us multicolored and equally often ingenious examples of the highest quality of the advertising art, but the reading of them is too often below our dignity. They go therefore unread, and by the pound, into that convenient circular file, the wastepaper basket. The representatives of the manufacturers sit in our waiting rooms, hoping that between patients, we can give them an impatient minute or two. How often are they sent on their way, unseen?

Fortunately for us, the typical allergic responses are obvious and are only too easy to recognize when they are anaphylactoid. Every physician should always have epinephrine and a syringe both within reach. The disposable needles with syringe attached can be removed from their plastic containers within seconds, and the physician, if he does not rush, has 30 to 45 seconds during which he can save a patient's life.

Less fulminating, but just as suddenly and usually without warning, small quantities of a drug previously taken with no adverse effects may cause mucous membrane edema, smooth muscle spasm, and urticaria or angioedema, or scarlatiniform, morbilliform or polymorphic erythematous rashes. We realize what has occurred, can take steps to cease using the drug, and can prescribe mild antihistaminic or corticosteroid hormones. But when the patient reacts

with a serum-sickness-like syndrome, any one or several or all of the typical signs or symptoms may be absent. The syndrome must therefore be recognized, although only one or two of the signs may be present.

Resembling these, but only superficially so because the basic mechanism is quite different, are the histaminic effects of some drugs as they affect the hyperhistaminic patient not necessarily allergic. When given slowly and in small quantities, these drugs will not cause histamine release. When they are given in larger amounts or when absorbed quickly, the patient then suffers from a pseudoallergic reaction. Such ill effects may be minimized by the concomitant administration of an antihistaminic agent. The reaction will not recur until there has been tissue cell histamine repletion. We are, because of this, puzzled when a second dose causes no reaction. Among other drugs which cause such histamine release are polymyxin, dextran, and pethidine.

We face another dilemma when we do not realize that a drug reaction may be due to a patient's genetic enzyme defect. As detectable by the glutathione stability test, anyone, sick or well, whose tissue cells lack glucose-6-phosphate dehydrogenase will react with hemolytic anemia when treated with primaquine, and also often with sulfonamides, para-aminosalicylic acid, or nitrofurantoin or again after exposure to naphthalene.

Similarly, methemoglobinemia may be seen during the first 90 days of life in infants who, exposed to nitrates in water or in aniline dyes, cannot enzymatically reduce the methemoglobin to hemoglobin. At least 10 such clinical entities are now recognized, and the fact that there may be more is suspected.

The corticosteroid hormones have brought with them a new type of problem. The signs of hypercorticism are so familiar that all of us can recognize a "moon facies" whenever we see one. What are we to do when such patients' lives actually depend on the continued use of the corticosteroid hormones when these have not only suppressed normal corticoid secretion, but have obviously brought on the signs of excess exogenous corticosteroid effects? The patients are rarely if ever happy to return to the use of safer although less satisfactory drugs.

You may view with alarm the fact that, in the United States, there are more than 500,000 people who are allergic to penicillin. The number increases year by year. You can be astonished at the fact that annually in the United States, more than 600,000,000 doses of penicillin are administered, and that this number excludes both the oral and the U.S.P. preparations. At first glance, you may be comforted by the fact that, for every 10,000,000 injections given, only 25 patients will react anaphylactically, and that of these only three will die.

Statistics and that part of the subject which represents what is truly only the odds tell us only the issues upon which we are gambling. They possess a peculiarity of which the implications are not always apparent. To say that three patients in 100 may suffer reactions sounds as though there is little if anything to give anyone concern. We can take care of three patients. The same odds can be represented by 30,000 in 1,000,000 and 300,000 in 10,000,000 or 3,000,000 in 100,000,000. We suddenly realize that 300,000, for example, represents a mighty large crowd of sick people. Supposing a total of one billion injections is given each day. The death rate becomes a staggering number.

You can similarly look on the deaths caused by automobile accidents. We are told that these occur once for every 15 million or more miles driven by all gasoline-powered vehicles. On this basis, an automobile is a fairly safe place in which to sit. But, look at it from another point of view. Over a Labor Day week end 7,000,000,000 miles will be driven, and approximately 700 people will lose their lives, one for every 10,000,000 miles. The 700 is a large number of needless deaths, and the fact is reported in the headlines. But more patients die of injections of antibiotic agents, some given unnecessarily, and there are no headlines.

We can further relate travel by automobile and drug administration. Let us examine an unlighted intersection of two roads. When, at such a point, a number of accidents occur, a traffic light is installed. The accident rate then usually and promptly increases. The reasons are easily understood. The driver approaching a green light now looks at the intersection as though the green light gives him an absolute right of way. The driver on the intersecting road may not have seen the red light, or its significance may not have been appreciated, or he may have gambled that he could safely run through it. While each light is on, it represents an absolute. But, if instead of lights there were revolving arrows traversing corresponding areas of red, yellow and green, then all drivers

and pedestrians would see not absolutes as green or red, but instead the relationships and the times involved in each. They would act more in accordance with such relationships. The brain then becomes an organ of first and not of last resort.

Although some drugs appear to carry red lights, and some appear to carry green lights, all should be looked upon as though they carried yellow blinking lights, or no lights at all. We would then all of us all of the time proceed with caution.

There is so much that we do not know. We cannot at first, and in many cases ever, discover why a patient responds adversely to a drug. We do not know why, when a reaction does occur, it happens just then, and usually at a most inconvenient moment. We are ignorant as to why the patient reacts to one ordinarily harmless substance, and not to another. We have no present method which will indicate why the chief adverse effects are to be seen in one organ or tissue, and compared to another. Lastly we have no idea as to what determines the type of response in the one organ or tissue as compared to another.

Resolving the Dilemmas

Where does this leave us? For the moment, a first and only a partial solution of the problem is to learn all we can of any drug we use. In all other fields of medicine, everything else we learn is a continuation of or can be referred to what has gone before. But a new class of drugs is not related in any way to any subject in which we were ever formally trained.

A second and another part of the solution of our problem is to know all we can learn of the classical course of the disorder under treatment. The slightest deviation from its classical course should first direct our suspicion to the drugs prescribed. This is not as difficult a point of view to acquire as at first appears.

We are also now duty-bound to tell each patient what drug he has reacted to in the past. He will then know what to avoid in the future, if only by being in the position to inform some other physician.

There is, as well, a moral and also a medico-legal obligation to pursue follow-up studies to uncover those effects known to occur long after the course of treatment is over. Should we follow these precepts, we will then help lessen the number of other doctors' dilemmas.

The usual references have purposely been omitted because they are all available in reprints of other papers on this same subject, available on request.

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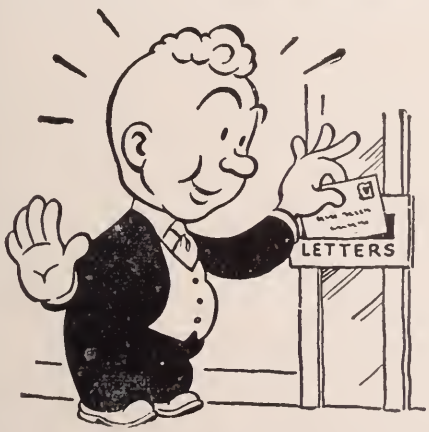

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April 8-11, 1960 Jacksonville, Fla.

Volume XLVI
Number 8

Central Angiospastic Retinopathy

An Ocular Vasoneurotic Syndrome

Thomas S. Edwards, M.D.
JACKSONVILLE

Central angiospastic retinopathy is a syndrome that should be of greater interest to all physicians, not the ophthalmologist only. It may be a forerunner of more serious lesions to come, both ocular and those of a systemic vascular nature, even essential hypertension.

Though the term central angiospastic retinopathy may be new to many, the syndrome is probably not unfamiliar. The patient usually complains of a sudden decrease in visual acuity, which then worsens over a period of hours or days. Often the patient will state after reading the 20/20 line that none of the chart looks right. It is all distorted. Upon checking, it will be found that this attack was most likely triggered by a psychic disturbance, strong emotions, exposure to cold, or exposure to a bright light. The physician should then investigate further instead of dismissing the patient as "another neurotic."

This syndrome was first described by von Graefe almost a hundred years ago. Since that time it has had numerous periods of prominence and neglect. Horniker,[1] in 1927, was the first to stress the relationship with intermittent claudication, angina pectoris, bronchial asthma, spastic colitis, and many other vasoneurotic entities. Shortly afterwards, Gifford and Marquardt[2] corroborated this relationship with cold pressor tests, oscillometry, and skin thermometer readings. It was further brought out during World War II when several hundred cases were reported, mostly in Naval personnel. Cordes[3] summarized most of the studies and thought that the most likely causes were allergic reactions to tetanus and yellow fever shots and emotional upset with vasomotor instability. These combined with overuse of tobacco resulted in angiospasm.

Pathologically, this disease is still much in doubt, especially so since most of the milder forms spontaneously remit. The spontaneous remission also makes the evaluation of the treatment most difficult. The unfortunate part is that these attacks may recur, and there may be permanent damage, even sometimes so great that the macula is completely destroyed.

An interesting, though not quite typical, case may help to illustrate the problem.

Report of Case

A 40 year old white man in the summer of 1955 suddenly noticed a haziness of the vision of the right eye. Under careful ophthalmoscopy, edema of the macula of the right eye was seen, even though the vision was still 20/20. This attack started when his son had an emergency appendectomy. The condition cleared promptly, either because of or in spite of the fact that he was given nicotinic acid. In January 1956, his sister was killed in an automobile accident, and he noticed a similar haziness of the left eye. This time funduscopic examination gave negative results, and the vision was normal. With a new testing method, however, it was shown that there definitely was spasm of the arterioles about the macula of the left eye. Again the eye cleared while he was taking nicotinic acid. In the summer of 1956, his mother died, and he had a recurrence in the right eye, in which there was questionable edema of the macula. Again, it was definitely shown that angiospasm was present. This time he refused treatment, and I understand that the condition again cleared. How long, however, will it be before this vasoneurosis is manifested in some more serious disease, such as, possibly, essential hypertension?

Diagnosis

Horniker[1] was the first to describe this syndrome adequately, and it has been only slightly modified in the ensuing 30 years. First, there is a sudden onset of diminished vision. This is usually described as a veil or haze over the eye with a pronounced discrepancy between the visual acuity and the subjective complaints, the loss of acuity often being minor. Second, the onset is frequently triggered by psychic disturbance or emotional upset, exposure to cold, or exposure to bright light. Third, the diminished vision is always unilateral and most commonly in the right eye. There is also a decided preponderance of men between 32 and 45 years of age. Fourth, the ophthalmoscopic findings are minimal or nil, especially with an ordinary ophthalmoscope. Only with the red free light is it possible to observe the minute fundal changes such as minimal hemorrhages and edema, and sometimes they are not visible at all. The visual field is often normal.

Lately, by using entoptic phenomena, one can more accurately diagnose and follow these attacks.

Read before the Florida Medical Association, Eighty-Fifth Annual Meeting, Bal Harbour, Miami Beach, May 5, 1959.

An entoptic phenomenon is a phenomenon whereby a person is able to see structures inside his own eye. By looking at a properly shaded blue sky anyone can see his own blood corpuscles in their paramacular capillary arterioles. They will be seen moving jerkily in curved paths synchronous with the pulse beat. These corpuscles are thought to be in the arteriolar loops in the inner nuclear cell layer. One can also see a central clear area where the cells never move and this is thought to be the avascular foveal region. With a new instrument introduced by Priestley and Foree,[4] one is able to study more uniformly this area and the corpuscles circulating therein. This instrument contains a strong light, special filters and several focusing lenses. In a patient with an angiospastic attack there always is the other normal eye to act as a control. When no cells or only a few cells are seen, there is a severe spasm. As the spasm subsides, the number of cells seen more nearly equals those seen in the other eye, and the symptoms decrease. Through this instrument it has been possible to make a definite diagnosis in cases in which the syndrome would otherwise have been unproved. Also, one is able to evaluate the treatment by the response in the increase in cells.

Treatment

The treatment is still much in question, especially since there is often a spontaneous cure without treatment. Cortisone has been used in a large number of cases, and there is a wide variance of responses. Some authors have reported great success and others complete failure on using the steroids. In my series of 50 cases, I had little success with the steroids. I had the best response with nicotinic acid, one of the oldest vasodilators. This is corroborated by Jacobson,[5] who has positively shown, with the aid of the electroretinogram, that intravenous nicotinic acid dilates the retinal arterioles and capillaries. My result was similar in testing with the entoptoscope. Numerous other vasodilators have also been used. Harrington[6] and his group used limited psychotherapy in a few cases, and they thought that it was most efficacious. In addition, antihistamines, sedation, and extra vitamins have been used successfully. Of course, if the focus, or cause, can be found, it should be eliminated in so far as possible. Efforts at elimination would include the avoidance of cold, worry, excitement and tobacco. These are all difficult to evaluate since in the mild cases there is spontaneous response. Further, in the serious cases there is much overlapping and confusion with many other retinal, choroidal, and chorioretinal lesions.

Summary

Central angiospastic retinopathy is a syndrome that should be of greater interest in all fields of medicine. It appears to be closely related to the other vasoneurotic lesions throughout the body. With newer instruments one is now able to diagnose it more accurately and to follow the treatment. Even though there are several successful methods, the best form of therapy is still in doubt.

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Discussion

Dr. Shaler Richardson, Jacksonville: Dr. Edwards has described a most interesting and challenging syndrome. I say challenging for the reason that so little has been done to determine the mechanism and pathology of the condition.

Cordes in 1944 reviewed 176 cases studied in various Naval hospitals. He found the lesion limited primarily to the fovea, and as Dr. Edwards has brought out, it starts with macular edema and loss of foveal reflex. Blurring of vision and a boring retrobulbar headache are the outstanding symptoms.

In the early stages it may be difficult to observe the lesion. Later, fine pigment changes can be detected, and subsequently a honeycombed macula can be visualized. A hole in the macula eventually may result.

The vision in Cordes' cases varied from 5/200 to 20/20 plus, but most eyes recovered with good vision. This syndrome is one that occurs in the younger age bracket between 20 and 30. A central scotoma is usually present, but disappears with the subsidence of the edema.

I have observed six patients with this condition; all have recovered. Four of the six had vasomotor instability, and an emotional factor was present in three. Vision at the time of onset varied from 20/25 to 20/40, but the average recovered vision was 20/25. The edema of the fovea and adjacent area was present in all. A central scotoma was plotted in four of the six patients; in all of these it disappeared. Pigment disturbance was a sequela in two of the six patients.

Vasodilators have been the only suggested treatment, and most authorities find that they are of doubtful value. In the six cases I have observed, nicotinic acid was used orally or intravenously. Steroids were administered in two of the six patients.

May I ask Dr. Edwards if he has found in the literature a recorded pathologic study of central angiospastic retinopathy?

Dr. W. Dean Steward, Orlando: Dr. Edwards is to be congratulated for bringing this poorly understood subject to our attention, and for shedding new light on it through the diagnostic procedures that he has described. There is little in the current literature about the

subject, and only after considerable search was I able to find anything worth mentioning in texts on ophthalmology. In the second edition of Sorsby's "Systemic Ophthalmology," published by Mosby, there is almost a page devoted to this subject. In essence, it agrees with Dr. Edwards' findings and recommendations. No specific suggestions are made as to treatment. It would appear to me, however, that some of the new vasodilator drugs would be of value.

It is hoped that this paper will stimulate interest in this clinical condition, and that not only ophthalmologists, but other clinicians, will be on the lookout for it.

DR. EDWARDS, closing: Dr. Richardson and Dr. Steward, thank you very much for your kind remarks. In this as in all diseases we hope to discover more about its etiology through pathologic study. As yet no early cases have come to the laboratory. Bertha Klein has studied a couple of severe chronic cases. They were, however, of no help as to the basic pathology, except that we know it originates in the retina. Someday, an early specimen will no doubt become available. Until that time we shall have to be content to study this syndrome through its clinical responses.

Triamcinolone in Dermatologic Therapy

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MARVIN F. ENGEL, M.D.
HARVEY BLANK, M.D.
MIAMI

The discovery by Fried and Sabo[1] that artificial steroids have a higher degree of anti-inflammatory activity than any of the previously known naturally occurring ones opened a new vista in the synthesis of these compounds. One of the newest in this series of wholly synthetic steroids is triamcinolone (9 alpha-fluoro-16-alpha-hydroxy prednisolone). Because of the reported superior anti-inflammatory effect of this steroid,[2-5] further experience with this drug is being reported.

Eczematous Eruptions

Rein, Fleischmajer and Rosenthal[5] reported a series of 26 patients, most of whom had atopic dermatitis. These patients showed marked improvement with decrease in erythema and relief of pruritus. Beneficial results were also observed in a few patients with dermatitis herpetiformis, exfoliative dermatitis, alopecia totalis and pemphigus erythematosus. Olansky, Callaway, Cook and McCormick[6] treated 66 patients with eczematous eruptions and had excellent or good results in all but two patients who had atopic eczema. Table 1 outlines our experience in the therapy of 36 patients with eczematous eruptions. Maintenance doses ranged from 2 to 12 mg., and the average duration of treatment was three months. There were no therapeutic failures in this group. Twenty-five patients, or 69 per cent, had excellent results and 11, or 31 per cent, had good results.

Psoriasis

Shelley, Harun and Pillsbury[7] in a report of 60 patients with psoriasis treated with triamcinolone found that 24 patients, or 40 per cent, did not respond, and of the 60 per cent whose lesions involuted, a regular recurrence with cessation of therapy was noted. Some of these patients were refractory to further steroid therapy.

Olansky and his associates[6] treated 25 patients with psoriasis. Twenty-three, or 92 per cent, achieved excellent or good results. Two relapsed while on therapy. Seven, or 30 per cent, of the 23 patients with good therapeutic results relapsed with reduction of the dosage of triamcinolone. Both groups of investigators suggested that triamcinolone not be used as a routine therapeutic measure in psoriasis, reserving its use for the severe, extending, uncontrolled psoriatic patient.

Our experience is outlined in table 2. One patient did not improve, but was treated for only eight days. One showed slight clearing after two weeks. The other seven had an excellent initial response; the disease, however, flared with a reduction of dose and was then uncontrollable on dosages greater than the original. In three patients who relapsed, generalized exfoliative dermatitis subsequently developed.

Miscellaneous Dermatoses

Olansky and his associates[6] treated 14 pa-

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Dr. Smith is a special postdoctoral fellow of the National Institute for Arthritis and Metabolic Disease.

Triamcinolone used in this study was supplied as Aristocort® by the Lederle Laboratories Division, American Cyanimid Company.

Table 1.—Triamcinolone in the Treatment of Eczematous Eruptions

Disease	Number of Patients	Maintenance Dosage	Results			Side Effects
			Excellent	Good	Poor	
Chronic eczematous dermatitis	11	2-8	7	4		Dizziness (1 patient) Perforating peptic ulcer (1 patient) Anxiety (1 patient) Ankle edema (1 patient)
Atopic dermatitis	3	6-12	3			
Lichen simplex chronicus	2	4-8		2		
Eczematous eruptions of hands	5	2-8	5			Moon face (1 patient)
Exudative discoid and lichenoid dermatitis	2	6-8	2			
Dermatitis venenata	13	2-12	8	5		Euphoria (1 patient) Depression (1 patient) Urticaria (2 patients)
Total	36		25	11		

Table 2.—Psoriasis

Number	Age	Sex	Duration of Disease	Maintenance Dose (mg.)	Duration of Treatment	Side Effects	Follow-up
1	26	M	7 years	12	2 weeks	None	Flared on 4 mg., then not controlled on 24 mg.
2	73	F	10 years	16	4 months	None	Flared on 8 mg., not controlled on 24 mg.
3	68	M	16 years	4	3 weeks	None	Flared when discontinued, then uncontrolled on 16 mg.
4	62	M	10 years	12	2 weeks	None	Slight clearing
5	44	M	10 years	12	1 month	None	Flared on 8 mg., then uncontrolled
6	18	F	5 years	12	8 days	None	No effect in 8 days
7	31	M	13 years	4	5 months	Exfoliated, moon face	Flared on 4 mg., then not controlled on 40 mg.
8	63	M	20 years	8	6 weeks	None	Good
9	44	M	12 years	12	1 month	None	Complete clearance

tients with erythema multiforme, 12 of whom had excellent results and two a good response. In our series, there were six patients with erythema multiforme, four of whom had the bullous form of the disease. Five showed excellent results. The sixth patient died after five days of triamcinolone therapy with a staphylococcal lung abscess and pneumonia.

Triamcinolone has also been reported to be extremely effective in lichen planus[6]. The one patient whom we treated showed good results in three weeks. Of the miscellaneous dermatoses shown in table 3, those responding with only poor or fair results include pityriasis rosea, lichen sclerosus et atrophicus, localized myxedema, and discoid lupus erythematosus. Those responding with good or excellent results included seborrheic dermatitis, stasis dermatitis, keratoderma palmaris et plantaris (figs. 1 and 2), chronic urticaria and subacute disseminated lupus erythematosus.

Special mention should be made of the excellent therapeutic results in three cases of myco-

Table 3.—Miscellaneous Dermatoses

Diagnosis	Age	Sex	Duration of Disease	Initial Dose	Maintenance Dose	Duration of Treatment	Result	Side Effect
Erythema multiforme	38	F	5 days	32 mg.	4 mg.	2 weeks	Excellent	Dizziness
Erythema multiforme	46	M	2 weeks	16 mg.	4 mg.	6 days	Excellent	None
Erythema multiforme bullosum	74	M	1 week	32 mg.	4 mg.	3½ weeks	Excellent	None
Erythema multiforme bullosum	58	M	5 days	16 mg.	16 mg.	5 days	Died	Staphylococcal pneumonia with lung abscess
Erythema multiforme bullosum	42	F	1 month	48 mg.	16 mg.	1 month	Excellent	Moon face, acne, exacerbated on 8 mg.
Erythema multiforme bullosum	30	M	2 weeks	16 mg.	4 mg.	2 weeks	Excellent	None
Lupus erythematosus, subacute	34	M	3 weeks	32 mg.	24 mg.	1 month	Good	Staphylococcal pneumonia, lung abscess, bronchopleural fistula (after 1 week), gastric irritation
Lupus erythematosus, discoid	46	M	2 years	12 mg.	12 mg.	3 weeks	Poor	None
Mycosis fungoides	36	M	12 years	40 mg.	32 mg.	1 year	Excellent	Moon face, asteatosis, anxiety, depression
Mycosis fungoides	59	M	10 years	20 mg.	20 mg.	2 months	Excellent	Purpura, ankle edema, diabetes mellitus
Mycosis fungoides	65	F	11 years	24 mg.	24 mg.	2 months	Good	Weight loss (10 lbs.) moon face
Pemphigus erythematosus	37	F	3 months	32 mg.	16 mg.	1 month	Good	None (1 month)
Dermatomyositis	54	F	1 month	12 mg.	12 mg.	1 month	Good	None
Seborrheic dermatitis	23	M	2-3 years	16 mg.	16 mg.	1 week	Fair	None
Seborrheic dermatitis	61	F	10 years	16 mg.	8 mg.	2½ months	Good	None
Stasis dermatitis	55	F	2 years	16 mg.	4 mg.	3 weeks	Good	None
Stasis dermatitis	73	F	4 years	12 mg.	8 mg.	1 month	Good	None
Lichen planus	52	F	3 weeks	12 mg.	4 mg.	3 weeks	Good	Monilial intertrigo
Pityriasis rosea	46	F	2 weeks	16 mg.	16 mg.	1 week	Poor	None
Parapsorasis	23	M	2 years	8 mg.	2 mg.	1 month	Excellent	None
Lichen sclerosus et atrophicus	52	F	4 months	16 mg.	8 mg.	3 months	Poor	Moon face
Keratoderma palmaris et plantaris	70	M	3 years	12 mg.	8 mg.	2 months	Good	None
Urticaria, chronic	45	F	3 years	20 mg.	4 mg.	3 weeks	Good	Flared on 4 mg., then uncontrolled on 8 mg.
Localized myxedema (pretibial)	44	F	8 years	16 mg.	4 mg.	1 month	Fair	Weight loss (8 lbs.) sore mouth

Fig. 1.—Soles of feet of 70 year old white man with history of keratoderma of hands and feet for three years.

Fig. 2.—Feet of patient in figure 1 after two months of triamcinolone therapy and a maintenance dose of 8 mg. daily.

sis fungoides, in one (figs. 3 and 4) of which the disease had become resistant to roentgen therapy. A similar case of roentgen-resistant mycosis fungoides responding to triamcinolone has been reported.[6]

Side Effects

Side effects reported with triamcinolone have included "moon face,"[2-4,6-8] hirsutism,[3,6-8] potassium loss,[9] weight loss,[2,3] muscle weakness,[8,9] leg and foot cramps, and petechiae and/or ecchymoses.[3,4,7,8] It has been shown in some instances that loss in weight occurred in patients who had been taking other steroids.[2,3] This loss stopped in these cases after an initial diuresis. We observed loss in weight in two patients and leg cramps in one. The development of "moon face" has been a frequent finding. In two patients in this series urticaria developed on triamcinolone therapy.[10] It disappeared with cessation of treatment and recurred upon reinstitution of the drug. In another patient a persistent glycosuria and elevated blood sugar developed and are currently controlled on tolbutamide. Mental disturbances developed in five patients, including euphoria, anxiety and depression. One patient experienced perforation by

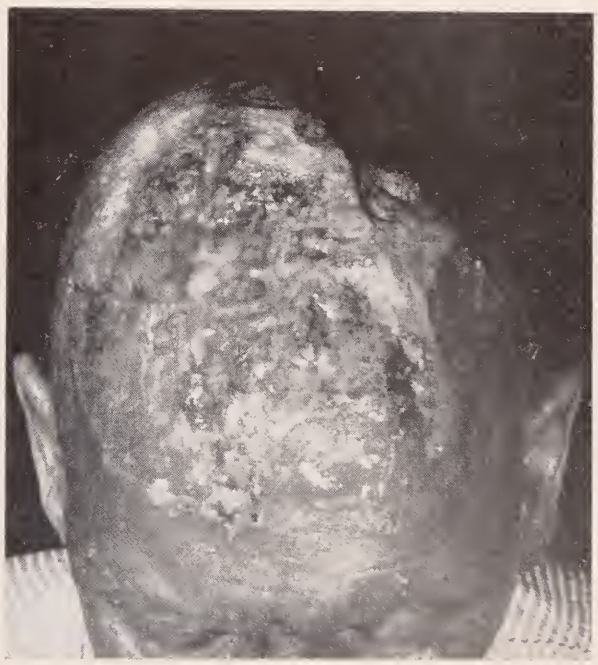

Fig. 3.—Scalp of 36 year old white man with mycosis fungoides of 12 years' duration. Scalp shows marked ulceration.

Fig. 4.—Scalp of patient in figure 3 after one month of triamcinolone, 32 mg. daily.

a silent peptic ulcer after one week on triamcinolone therapy on a dosage of 16 mg. a day. Perforation or severe bleeding of previously unsuspected ulcer has been reported.[9,11]

Hartung[3] had to discontinue the use of triamcinolone in the treatment of rheumatoid arthritis in several cases because of persistent respiratory infection. Dameshek and Rubio[9] reported the development of severe staphylococcal infections in patients on triamcinolone therapy. Our most serious side effect was severe Staphylococcus pyogenes var. aureus infection of the lungs. In one patient with erythema multiforme bullosum a staphylococcal septicemia developed, and the patient died. In the other patient pulmonary cavitation, bronchopleural fistula, pneumothorax and empyema developed, but recovery followed after reduction of dosage, surgical drainage and administration of antibiotics.

Summary

Fifty-eight dermatologic patients, of whom 36 had eczematous eruptions and nine had psoriasis, were treated with triamcinolone.

Triamcinolone generally was highly effective in the management of a variety of eczematous dermatoses. Psoriatic patients usually showed an excellent initial response; however, subsequent relapse and lack of control on increased dosage were nearly invariable. This drug should therefore be reserved for treatment only of severe uncontrolled psoriasis. Triamcinolone was useful in the management of erythema multiforme and subacute lupus erythematosus.

Triamcinolone appears to be especially effective in the treatment of mycosis fungoides and lichen planus. As with other steroids, serious side effects many accompany its use. A bland diet with antacids probably should be used routinely during triamcinolone therapy. Sudden development of infection, especially of the respiratory tract, may be a complication.

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Herniation of the Nucleus Pulposus: Experience in 600 Cases and Presentation of An Apparently Successful Attempt to Reduce The Necessity for Reoperation

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Although this is a short report, I have more than one purpose in making it: (1) to compare general results after operation for rupture (protrusion) of an intervertebral disc in two series of cases; (2) to compare information obtained in two studies of results of secondary operation in cases of rupture of an intervertebral disc; (3) to explain the importance of thorough evacuation of the intervertebral disc space in obviating the necessity of second or successive operations; (4) to describe, relative to the operative procedure, modifications I have made to facilitate evacuation of the intervertebral disc space; (5) to suggest that these modifications may have helped to reduce the necessity of secondary surgical procedures; and (6) to conjecture why secondary difficulty in some cases is at a level different from that of the primary difficulty.

General Results in Two Series of Cases

In 1952, Tsang and I[1] reported a series of 300 cases of rupture of the intervertebral disc, in which operation had been performed from 1947 to 1951 inclusive. Information concerning ultimate results, obtained by questionnaire, is presented in table 1; the quantities are derived from tables 11 and 12 of the previous paper.[1]

For comparison, results in a similar series of 300 cases, in which operation was performed from 1952 to 1956, are recorded in table 2. The percentages in tables 1 and 2 are almost identical.

Two Studies of Results of Secondary Operation

Of the patients represented in table 1, 23 required two or more operations in the period 1947 to 1951 inclusive. Data on these 23 patients are recorded in table 3; the quantities are derived from table 9 of the previous paper.[1] Because of what is to follow, it is best to note here that the data in tables 3 and 4 are divided into those that apply (1) to patients on whom I performed the primary operation and (2) to patients on whom another surgeon, elsewhere, performed the primary operation.

For comparison, a similar record appears in table 4. The patients represented required reoperation in the period 1952 to 1956 inclusive. Again there were 23 of them. Of the 11, however, on whom I had performed the primary operation, all had undergone that operation in the period 1947 to 1951 inclusive; that is, they were all of the first group of 300 patients.

Thus, all patients on whom I performed the primary operation in the five years 1947 to 1951 inclusive, and who returned to me for reoperation in the 10 years 1947 to 1956 inclusive, are enumerated. Data on these patients (12 from table 3 and 11 from table 4) are gathered in table 5.

It is evident in table 5 that approximately 8 per cent of the patients on whom I performed the primary operation returned to me for reoperation. I have no record of how many patients on whom I performed the primary operation went to other surgeons for secondary operation. I do know, however, that almost exactly half of the patients on whom I performed a secondary operation came to me after the primary operation had been performed by another surgeon, elsewhere. It seems safe to assume, therefore, that half of the patients for whom I was the first surgeon went to another surgeon, elsewhere, when a secondary operation was required. This would make the rate of reoperation among patients on whom I performed the primary operation somewhere between 8 and 15 per cent. The upper end of that estimated range in

Read before the Southern Neurosurgical Society, Miami Beach, Jan. 23, 1959.

Table 1. — Results of Operations Performed From 1947 to 1951 Inclusive; 143 of 300 Patients Responding to Questionnaire

Result in General		Patients	Per Cent of 143
Cured		24	17
Improved		102	71
Unimproved		13	9
Worse		4	3
Employment			
In comparison with employment before operation	Same	74	52
	Easier	56	39
Unable to work because of	Symptoms relative to operation	10	7
	Another condition than that for which operation performed	3	2
Morbidity*			
Back pain		62	43
Leg pain		67	47
Numbness		80	56

*Patients of this category number more than 143 because some patients complained of more than one of the listed symptoms.

Table 2. — Results of Operations Performed From 1952 to 1956 Inclusive; 190 of 300 Patients Responding to Questionnaire

Result in General		Patients	Per Cent of 190
Cured		39	20
Improved		134	71
Unimproved		14	7
Worse		3	2
Employment			
In comparison with employment before operation	Same	110	58
	Easier	57	30
Unable to work because of	Symptoms relative to operation	20	11
	Another condition than that for which operation performed	3	1
Morbidity*			
Back pain		107	56
Leg pain		97	51
Numbness		104	54

*Patients of this category number more than 190 because some patients complained of more than one of the listed symptoms.

Table 3. — Data on the 23 Patients (of the First 300) Who Required Secondary Operation in the Time Covered by the First Study, 1947 to 1951 Inclusive

Surgeon at Primary Operation	Patients Requiring Secondary Operation	Reason for Secondary Operation	Patients		
			Sub-totals	Relieved	Not Relieved
Author	12	Difficulty in disc space	4*	4	
			2†	2	
		Arachnoiditis	2	2	
		No cause found	4	3	1
Other than author	11	Difficulty in disc space	4*	3	1
			4†	2	2
		Arachnoiditis	1		1
		No cause found	2	1	1
Totals	23		23	17	6

*". . . rupture of the intervertebral disc at the same level as before, or, most probably, incomplete removal of nuclear material with secondary protrusion . . ."[1]
†". . . second herniation at a different level . . ."[1]

Table. 4 — Data on the 23 Patients (Author's 11 Cases All From the First 300) Who Required Secondary Operation in the Time Covered by the Second Study, 1952 to 1956 Inclusive

Surgeon at Primary Operation	Patients Requiring Secondary Operation	Reason for Secondary Operation	Patients		
			Sub-totals	Relieved	Not Relieved
Author	11	Difficulty in disc space	4*	4	
			4†	4	
		Arachnoiditis	2	1	1
		No cause found	1		1
Other than author	12	Difficulty in disc space	7*	7	
			2†	2	
		Arachnoiditis	3		3
Totals	23		23	18	5

*". . . rupture of the intervertebral disc at the same level as before, or, most probably, incomplete removal of nuclear material with secondary protrusion . . ."[1]
†". . . second herniation at a different level . . ."[1]

Table 5. — Data on the 23 Patients Represented in Tables 3 and 4, on Whom the Author Had Performed the Primary Operation*

Reason for Secondary Operation	Patients		
	Subtotals	Relieved	Not Relieved
Difficulty in disc space at same level as before	8	8	
Difficulty in disc space at different level than before	6	6	
Arachnoiditis	4	3	1
Osteomyelitis	4	3	1
No cause found	1		1
Totals	23	20 (87%)	3

*Primary operation on all of these patients was performed in the period 1947 to 1951 inclusive; some of the secondary operations were performed in the years 1947 to 1951 inclusive and some in the years 1952 to 1956 inclusive.

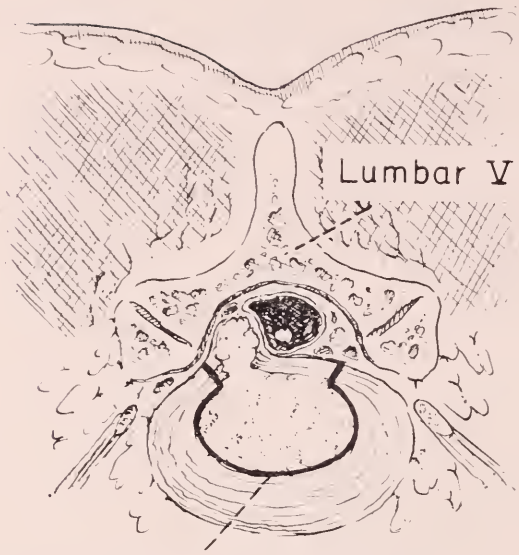

Fig. 1.—Diagram showing extent of disc removal.

rate corresponds with the rate given by Svien,[2] in commenting on a paper published about four years ago. Whatever rate has been attained, surgeons have striven to lower it, and numerous procedures have been tried.

Evacuation of the Intervertebral Disc Space

For instance, various types of bony fusion have been tried, both at primary and secondary operation. Some orthopedic surgeons have advocated fusion at the primary procedure. Barr[3] wrote: "The question whether or not disc excision should be accompanied by fusion cannot be answered by an unequivocal 'yes' or 'no'." He continued: "Although indubitable statistical proof of the superiority of the combined fusion-excision operation is not yet available, there is strong evidence to support this view. Having made that statement, let us qualify it as follows. There is some additional operative risk in adding fusion to disc excision, and it should be omitted in cases with cardiac or other complications."

Others have emphasized the importance of thorough removal of disc material. In the series of Greenwood, McGuire and Kimbell,[4] the rate of reoperation was about 10 per cent (67 of 632 cases). Results of reoperation generally were good; the authors reported "failure of surgery" in only 5 per cent of the 632 cases. They wrote that one of the values of reoperation is that the knowledge gained thereby may reduce the number of patients who need reoperation. Among matters to which they drew particular attention were "that there be no loose pieces of cartilage left behind, above, or below the interspace, attached to the nerve root or in the intervertebral foramen, and that no nuclear material be left in the intervertebral space."

Concerning freedom from intervertebral rigidity after curettage, Foltz, Ward and Knopp[5] reported good results on short follow-up investigation of 16 patients who had undergone "laminectomy and disc excision" with "maximum removal of the disc possible and thorough curettement of the cartilage plates in the intervertebral disc space." One year after operation, "convincing intervertebral motion was present at the level of operation in 15 of the 16 patients, thereby indicating that intervertebral fixation had not occurred."

The discussion by Svien[2] has been mentioned. He emphasized the importance of complete evacuation of the disc space and Ghormley,[2] in the same discussion, said that removal of the disc gave the best results in treatment of recurrent protrusion.

Modification of the Operation to Insure Evacuation of the Disc Space

In consonance with the experiences and opinions just recounted, for my second 300 cases (1952 to 1956 inclusive), I enlarged and extended the surgical procedure in an effort to reduce the number of recurrences and secondary operations. I abandoned the unilateral approach in favor of a radical bilateral procedure. The involved space was opened through the usual interlaminar approach. If rupture of the annulus and herniated nucleus pulposus was identified, the nucleus pulposus was eradicated as completely as possible with bilateral exposure. Moreover, the annulus was entirely removed, from nerve root to nerve root; thus, the surgeon could not miss concealed fragments of nucleus lying in the midline, anterior to the dural canal. The Schreiber neurosurgical light was used to illuminate the interbody space. Without such illumination, to attempt complete removal of the nucleus pulposus is dangerous.

The additions to the usual procedure that have been described require little extra time. Perhaps, too, it is an advantage that they make performance of the disc operation a little less spectacular than is the removal of a single large piece of herniated nucleus from beneath the offended nerve root.

A Possible Favorable Effect of the Radical Bilateral Procedure

A few paragraphs earlier, it was said that the rate of reoperation in cases in which I performed the primary procedure probably lies somewhere

between 8 and 15 per cent. That estimate, however, is based on the first 300 cases, wherein the radical bilateral procedure was not used. I employed that procedure in the second 300 cases, and it is too soon to base conclusions on them. Thus far, however, of the second 300 patients, subjected to primary operation from 1952 to 1956 inclusive, only three have returned for reoperation. I could not find any cause for the symptoms of two of them and, concerning the third, a single small piece of nucleus had worked out and had come to rest under a nerve root. The difference between results of the first five years and the second five years seems to indicate improvement. It may prove to be significant. If so, the reason for the betterment may well be the change from the conservative to the radical operation.

A Conjecture as to Why the Level of Secondary Difficulty Sometimes Is Different From That of the Primary Difficulty

In eight of the 23 cases represented in table 5 the level of the second operation was the same as that of the first operation; in six, the levels of the two operations were different. Myelograms had been made in all the cases and, in the six cases in which the level of the difficulty changed, abnormality had not been found at the level where the second operation eventually became necessary. It seems likely, then, that the difficulty at the second level was a new one, without relation to any previous operation. Yet possibly asymmetry of a disc space, resulting from only partial removal of the nucleus, could give rise to abnormal postoperative stress on an adjoining disc. This, however, is difficult for me to believe.

As has been said, only three patients of those on whom I performed a primary operation in the years 1952 to 1956 inclusive have returned to me for reoperation. Neither among them, nor among the 12 (table 4) who came to me for reoperation after primary operation by other surgeons, elsewhere, did I find any whose second difficulty was at a new level. I have no explanation for this other than that it may be the result of chance distribution.

Summary

Operations for herniation (protrusion) of the nucleus pulposus were performed on two series of patients, each numbering 300. In the first series, operations were performed from 1947 to 1951 inclusive; in the second series, from 1952 to 1956 inclusive. On follow-up investigation, results as to improvement or unimprovement, employment and morbidity were generally good and were similar in the two series. Results obtained in two studies of the effect of secondary operation also were generally good and similar in the two studies. Thorough evacuation of the intervertebral disc space is important in prevention of the need for reoperation and seemed to be favored by a radical bilateral approach. The incidence of reoperation in cases in which I had performed the primary operation, and had not used the radical bilateral approach, ranged between 8 and 15 per cent. After I had changed to the radical bilateral operation, my incidence of secondary operation apparently fell abruptly, although it is too early to justify conclusions in the matter. Why secondary difficulty sometimes occurs at a different level from that of the primary difficulty remains conjectural.

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Developmental Evaluation Clinic

A New Diagnostic and Counseling Service for Pre-School Children

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MIAMI

The Developmental Evaluation Clinic is a service concerned with the comprehensive evaluation of the pre-school child (0 through 6 years) whose development reflects some degree of retardation. In addition, it functions to counsel the parents of the retarded child. The clinic was made possible by a special grant from the U. S. Children's Bureau to the Bureau of Maternal and Child Health of the Florida State Board of Health. Administration of the clinic is under the Dade County Health Department. The clinic began operation in January of 1958. The general philosophy under which the clinic operates is well stated in the grant: that the clinic conduct its activities in an inquiring and exploratory fashion in order to determine exactly what goes into the evaluation process for it to be more than just a simple and routine diagnostic procedure.

Magnitude of Problem

Masland's excellent review[1,2] of the subject of mental retardation gives us some insight into the magnitude of the problem. Of the 4,200,000 children born annually in the United States, 3 per cent (126,000) will never achieve the intellect of a 12 year old child, 0.3 per cent (12,600) will remain below the seven year intellectual level and 0.1 per cent (4,200) will be completely helpless and will not be able to care for their basic needs.

Yannet[3] pointed out that the largest group of the mentally retarded (75 per cent) will have an I.Q. between 50 and 75. He stated that this group is responsive to training and supervision and can be successfully integrated into an industrial or rural society. The next group with an I.Q. of 25 through 50, comprises 20 per cent of the retarded group. A certain portion of this group can be helped on a local basis if adequate diagnostic and training facilities are available.

Clinic

The clinic staff consists of a Pediatrician who serves as Director, a Psychologist, a Psychiatric Social Worker, and a Public Health Nurse. The evaluation process includes a complete medical work-up followed by indicated laboratory procedures, a thorough family sociologic study by our social worker and psychometrics by our psychologist. Special examinations are obtained through our consulting staff, which is made up of a Neurologist, Child Psychiatrist, Otolaryngologist, Speech Therapist and an Orthopedist-Physiatrist. Electroencephalography, pneumoencephalography, audiometry and speech evaluation are done when indicated by the child's condition.

Once the child's work-up is completed, the clinic staff meets as a group to evaluate the clinical data. During the meeting, the clinical data relating to the child are discussed and the total problem is reviewed. This includes consideration of the family structure as well as the availability of local community services. Ideas are exchanged about the patient's problem, as seen by the individual members of the clinic team. This discussion gives us a comprehensive knowledge of the problem. Decisions reached during this meeting are then discussed at another group meeting with both parents present. A program is set up for the child based on the clinic's findings and the parents' needs and wishes. When a home training program is recommended, our public health nurse makes periodic visits to the home and submits progress reports to the clinic. During her home visit, the nurse offers suggestions and gives guidance to the family about the developmental training of the child. When it is thought that for any reason the home training program is not appropriate, the parents are helped to make other constructive plans through local and state facilities. Re-evaluation is carried out at regular intervals or when indicated by the child's progress.

Aims

The purpose of the clinic, in addition to its diagnostic service, is to counsel parents and to determine what services are necessary and available for the proper training and guidance of the

mentally retarded child. At the present time local training facilities available to us in the community are limited both in number and in scope. It is the opinion of some authorities working with retarded children that a large portion of these children could be trained on a local basis if proper facilities and personnel were available. Some of the data accumulated at our clinic, so far, would substantiate this fact. Many of the families seen here want to keep the retarded child within the family unit, but think that they need guidance to do so. Parents are apprehensive about the future of the child when no constructive program is offered.

Our approach to the question of guidance is not that of telling parents what should be done with their retarded child with regards to institutionalization or local care. These decisions are highly personalized and the sole responsibility of of the parents. When it is possible, we try to prognosticate the child's future development and explain what services are available on a local basis for training. The information that is gathered about a particular patient and his family is presented to the parents in such a manner as to help them evaluate their own needs and desires. This information is sent back to the referring physician or agency.

Exploratory Activities

The approach to mental retardation is a complex one and involves various talents. To be sure, making a definitive diagnosis as to the cause of retardation does not solve the patient's or the family's problem, but merely initiates the next logical step, which is, what can be done to help the retarded child. The retarded child's problem is intimately mingled, in certain instances, with psychologic overtones, inner family conflict, some of societies' archaic beliefs, and lack of training facilities and trained personnel to meet their needs.

From our diagnostic findings we hope to show where basic research is needed and will be most fruitful. Through our social worker we hope to explore the needs of the family unit, what conflicts are present or predictable in the future, and how these problems may be solved. Our psychologist is evaluating the factors which enter into the test situation and influence the final test numeral (I.Q.) and how this numeral is related to performance at later age levels. In general, we are evaluating very young children (ages 0 through 6 years) where testing is more difficult and standards established for the older retarded child do not completely apply. In addition, the clinic must continue to raise questions, for example, how might information best be communicated about these retarded children to responsible persons such as parents, the family physician, and the various agencies in the community.

One of the immediate problems facing us is that of training for the young retarded child. What positive steps, such as home training and special services, are feasible in the light of the particular family situation? What progress can be made by severely as well as moderately retarded children, while at home, which might better equip them to attend school when they reach school age? What type of home training will be most beneficial in preparation for institutionalization if and when placement is necessary?

As already recognized in a few communities, it has become apparent to us that a network of services is necessary to provide a positive approach for the training and care of the young retarded child. Among these services there should be local day care centers and specialized kindergartens supervised by personnel with special training in the field of teaching retarded children. By such a community program, one would hope to reduce significantly the need for institutionalization, or to shorten the period, if indicated. Associated with the day nursery, a "short stay" residential home might be established for a limited number of children. It is believed that this service would help the patient or the family over a temporary crisis and thus avoid permanent institutionalization.

Referrals and Fees

Patients are referred to the clinic by private physicians, health and welfare agencies and direct requests from parents. Appointments to the clinic from counties other than Dade must be made through the Health Officer or Health Department in the respective county. The Department must be willing to send a Social Worker or a Public Health Nurse to attend the Disposition Conference which is held on the last of the three days required for the clinic's evaluation. The clinic staff works in close relationship with the family physician or clinic directly responsible for the medical care of the child. The basic services of the clinic are free of charge. Any tests or services, however, which are obtained outside the clinic are paid for by the parents when possible.

Under certain circumstances the clinic absorbs the cost of these tests.

Teaching

The Development Evaluation Clinic and staff are closely allied with the teaching services of the University of Miami School of Medicine. The clinic makes use of the advanced diagnostic and research technics offered by the University Medical Center. In addition, clinic facilities are available for the training of medical students, nurses and other personnel so that they will be aware of the latest technics used in diagnosis and care of mentally retarded children.

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ABSTRACTS

Chronic Purulent Postnasal Discharge: EFFECTIVENESS OF ANTIMICROBIAL AGENTS AS A THERAPEUTIC SUPPLEMENT. By A. R. Hollender, M.D. A. M. A. Arch. Otolaryng. 69:170-173 (Feb.) 1959.

Although chronic purulent postnasal discharge and chronic "postnasal drip" are used synonymously by some authors, the terms designate different processes attributable to different causes, Dr. Hollender points out, and the one must be distinguished from the other to rationalize therapy. Although some similarity exists in the mechanism and etiology of the two processes, the drainage product in chronic "postnasal drip" usually is nonpurulent. In a study of 50 patients with chronic purulent postnasal discharge conventional therapeutic measures produced favorable results in only 10 of the patients. With the supplemental use of specific antimicrobial agents, in the remaining 40 patients therapeutically uninfluenced by conventional measures, favorable effects were obtained in 24, or 60 per cent in contrast to 20 per cent. The results of this investigation demonstrated the significant value of antibiotic specificity—supplementing the conventional treatment of chronic purulent postnasal discharge with the administration of (specific) indicated antimicrobial agents.

Thromboangiitis Obliterans Affecting Women. REPORT OF A CASE AND REVIEW OF THE LITERATURE. By Edward L. Cutler, M.D. Angiology 10:91-98 (April) 1959.

In an effort to explain the low incidence of thromboangiitis obliterans in women and to contribute to the understanding of the disease, the author here reviews the clinical features of the entity among women in the English literature. Of 69 cases reported, he considered 52 acceptable, six doubtful, and 11 not acceptable. He also discusses the possible etiologic factors, giving consideration to sex incidence, race, heredity, age, endocrine factors, infection and tobacco. He reports a single case of thromboangiitis obliterans occurring in a woman with description of pathologic material obtained by ulnar artery biopsy.

Hodgkin's Disease, Lymphosarcoma, Multiple Myeloma and Chronic Leukemia. By Ralph Jones, Jr., M.D., Ulfar Jonsson, M.D., and Jacob Colsky, M.D. Chapter in Long-Term Illness: Management of the Chronically Ill Patient, edited by Michael G. Wohl, M.D., F.A.C.P. Philadelphia, W. B. Saunders Company, 1959.

In this chapter on the management of Hodgkin's disease, lymphosarcoma, multiple myeloma and chronic leukemia, the authors first discuss Hodgkin's disease, stages I, II and III, with particular attention to diagnostic studies, prognosis and follow-up in the first two stages. Under stage III they discuss in detail chemotherapy with nitrogen mustard, triethylene melamine (TEM), chlorambucil (CB 1348, Leukeran) and triethylene thiophosphoramide (TSPA, thor-TEPA); follow-up; treatment of relapse; and hematologic, neurologic (paraplegia, central nervous system involvement) and renal (uric acid uropathy, direct involvment of the urinary tract) complications, also the superior caval syndrome and pleural effusion. The general principles of management of lymphosarcoma they describe as identical with those for Hodgkin's disease. Under mul-

tiple myeloma they deal with the solitary plasmacytoma and particularly with the widely disseminated form of the disease, discussing Urethan and ACTH and the glucocorticoid hormones in treatment as well as other therapeutic measures. The complications reviewed include renal and neurologic complications and osteoporosis and pathologic fracture. Although the optimal method of management of chronic leukemia is not at present clearly established, they conclude that it probably is the judicious use of radiation therapy and chemotherapy, used alternately in a highly individualized manner and in proper sequence.

These authors present the relative merits of radiation therapy (using x-radiation, gamma radiation from a cobalt source, or radioactive phosphorus) and chemotherapy in the treatment of chronic lymphatic leukemia. The complications of hemolytic anemia and thrombocytopenia are discussed and also the variable prognosis in this disease. They point out that the choice between irradiation and chemotherapy in the treatment of chronic myelogenous leukemia is not established. In their opinion radioactive phosphorus may be superior to radiation from an external source, and they regard Myleran as the chemotherapeutic agent of choice. They discuss acute myeloblastic relapse and other hematologic complications as well as splenic infarction and other complications.

This comprehensive coverage of present methods of treatment of these diseases which are an important factor in long term illness is clearly presented and well documented.

Unusual Foreign Body (Steinmann Pin) in Bladder. By Raymond J. Fitzpatrick, M.D. J. A. M. A. 170:671-672 (June 6) 1959.

A case is reported in which a Steinmann pin from a hip pinning seven years previously migrated into the urinary bladder of a pregnant woman. The original orientation of the pin suggests that the pointed end first entered the bladder and that calcification of the distal end occurred only after the entire pin was intravesical, or nearly so. The patient denied having had any operations in the past and was therefore cross-examined regarding attempted abortion. At operation, the pin, 9.5 cm. in length and partially encrusted by a stone measuring 4 by 3 cm. in diameter, was found lying free in the bladder cavity. The postoperative course was uneventful, and two months later the patient had a normal delivery.

Hydatidiform Mole: A Review of the Diagnosis, Management and Follow-up—and Choriocarcinoma. By A. S. Goss, Jr., M.D. South. M. J. 52:439-442 (April) 1959.

The incidence, etiology, signs and symptoms, diagnosis, treatment and prognosis of hydatidiform mole and choricarcinoma are reviewed, and the clinical care of patients with these lesions is outlined. A case of benign hydatid mole is reported.

Prochlorperazine in Emotionally Disturbed, Mentally Defective Children. By C. H. Carter, M.D. South. M. J. 52:174-178 (Feb.) 1959.

Of children with neuropsychiatric disorders, emotionally disturbed mental defectives present one of the greatest challenges to treatment. In this study, prochlorperazine was administered to 82 emotionally disturbed mental defectives, 70 of whom were under 21 years of age. The emotional disturbances and the mental deficiencies were moderate or severe in all patients. The optimum daily dosage of prochlorperazine for nearly half of the patients was between 30 and 75 mg. Twenty-two patients required 150 mg., and 15 patients required 300 mg. or 600 mg. Response of the mental and emotional disorders was excellent or good in all but one patient. Prochlorperazine effectively reduced hyperactivity and relieved schizophrenic reactions; it produced a considerable degree of improvement in ward and cottage behavior, table training, and toilet training. The drug appeared to reduce the incidence and severity of epileptic seizures, preseizure and postseizure tension, and the dread of approaching seizures.

Prochlorperazine appeared to produce no serious side effects. Extrapyramidal symptoms, drowsiness, and catatonic-like state were infrequent and transient, or were overcome by adjunctive medication. The drug was withdrawn from one patient with extrapyramidal symptoms, which proved reversible. It was concluded that prochlorperazine is a generally effective, rapidly acting, safe medication for the emotionally disturbed mental defective.

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 2411, Jacksonville, for abstracting and publication in The Journal. If you have no extra reprints, please lend us your copy of the journal containing the article.

Laws of Medicine

Last month, at the beginning of the year, I proposed some Resolutions I believe we urgently need to adopt if we are to remain a progressive and independent profession. The first was "BE IT RESOLVED that we live up to the heritage we have received from our forefathers in Medicine, and continue to earn and deserve the privileges and esteem awarded to our profession by a grateful public as we keep our ideals, ethics and scientific knowledge on a most high plane."

To accomplish such, we must adhere more strictly to the rules and laws of Medicine and the suggestions for proper medical etiquette and ethics handed down to us through the centuries required to develop modern Medicine.

Sound philosophical concepts of medical behavior and requirements have really not changed at all since Hippocrates wrote the Law of Medicine about 400 B.C. Since it is well for all of us to re-read from time to time this law upon the principles of which Hippocrates later formulated The Oath, I am having it copied on the opposite page.

Additional remarks about laws governing Medicine came to us at about the beginning of modern Medicine from Pierre Louis about 1830 when he wrote, "Think for a moment of the situation in which we physicians are placed. We have no legislative chambers to enact laws for us. We are our own lawgivers; or rather, we must discover the laws on which our profession rests. We must discover them and not invent them; for the laws of nature are not to be invented. This is my conviction, and I know very well that everyone will not be of the same opinion; but what matters it, if you look upon a physician as I do, holding a sacred office, which demands greater sacrifices than are to be made in any other profession."

There is no doubt but that we need changes from some of the modern day professional attitudes, but the change we need most is to stop the transgressions from these original early teachings and adhere to the professional etiquette, moral and ethical principles taught years and centuries ago by the fathers of organized Medicine.

The Law of Medicine

MEDICINE is of all the Arts the most noble; but owing to the ignorance of those who practice it, and of those who, inconsiderately, form a judgment of them, it is at present far behind all the other arts. Their mistakes appear to me to arise principally from this, that in the cities there is no punishment connected with the practice of medicine (and with it alone) except disgrace, and that does not hurt those who are familiar with it. Such persons are like the figures which are introduced in tragedies, for as they have the shape, and dress, and personal appearance of an actor, but are not actors, so also physicians are many in title but very few in reality.

WHOEVER is to acquire a competent knowledge of medicine, ought to be possessed of the following advantages: a natural disposition; instruction, a favorable position for the study; early tuition; love of labor; leisure. First of all, a natural talent is required; for, when Nature opposes, everything else is in vain; but when Nature leads the way to what is most excellent, instruction in the art takes place, which the student must try to appropriate to himself by reflection, becoming an early pupil in a place well adapted for instruction. He must also bring to the task a love of labor and perseverance, so that the instruction taking root may bring forth proper and abundant fruits.

INSTRUCTION in medicine is like the culture of the productions of the earth. For our natural disposition is, as it were, the soil; the tenets of our teacher are, as it were, the seed; instruction in youth is like the planting of the seed in the ground at the proper season; the place where the instruction is communicated is the food imparted to vegetables by the atmosphere; diligent study is like the cultivation of the fields; and it is time which imparts strength to all things and brings them to maturity.

HAVING brought all these requisites to the study of medicine, and having acquired a true knowledge of it, we shall thus, in travelling through the cities, be esteemed physicians not only in name but in reality. But inexperience is a bad treasure, and a bad fund to those who possess it, whether in opinion or in reality, being devoid of self-reliance and contentedness, and the nurse both of timidity and audacity. For timidity betrays a want of powers, and audacity a want of skill. There are, indeed, two things, knowledge and opinion, of which the one makes its possessor really to know, the other to be ignorant.

Those things which are sacred, are to be imparted only to sacred persons; and it is not lawful to impart them to the profane until they have been initiated in the mysteries of the science.

Hippocrates

VOLUME XLVI
NUMBER 8

THE JOURNAL
OF THE
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Welcome Aboard

The entire membership of the Florida Medical Association joins The Journal in saluting our two new County Medical Societies.

The addition of the Charlotte County Medical Society and the Highlands County Medical Society is an auspicious and encouraging sign. It brings to 39 the number of separate County Societies within our Florida Medical Association. In addition, it indicates the increasing and ever widening interest in the affairs of the State Association that is being shown by the individual Physicians and groups of Physicians everywhere. All of us are becoming more and more aware of the personal importance of the many problems that face organized Medicine today. Indeed, it is a heartening sign to watch our Association grow and develop, structurally and professionally.

To these new and relatively small Societies, the remainder of the component societies extend the hand of friendship and congratulations — a welcome to the confederacy. The staff in Jacksonville urges all of your members — and especially your officers — to visit the Association's Headquarters to experience in person the friendship and assistance that are available for the asking. Come and see the many facilities and services that are provided for you.

Let me hasten to add that the older component Societies recognize that whatever help we can extend to you will be more than matched by what you can do for us. The periodic infusion of new thoughts—new ideas—new stimuli—into the lifeblood of our organization is an ever-welcome and vitally essential part of our continuing healthy state. Certainly all of us will look to you, as the youngest members of our fraternity, to supply much of the vigor, the enthusiasm and the vision that we will need on the road ahead.

Perhaps the fact that these two new Societies were added during the year 1959 — in which the United States of America also increased by two additional units — is a significant one. Perhaps it confirms our faith that Florida Medicine is at least keeping pace with the national medical advances. In any event, all of us in the Florida Medical Association are glad to have you aboard and know that your interest, enthusiasm and enterprise will be an inspiration to us.

J. W. A.

Diagnosis and Differential Diagnosis of Hyperparathyroidism

Marked skeletal demineralization and its sequelae, a prolonged history of urolithiasis, severely damaged kidneys, unequivocal elevation of the serum calcium and alkaline phosphatase concentrations with depression of the serum phosphorus — such was the textbook picture of hyperparathyroidism a decade and more ago. Today it is generally realized that such findings represent far advanced hyperparathyroidism and are seen in only a small proportion of the total number of cases of active hyperparathyroidism. The development of a syndrome of this severity represents either negligence on the part of the patient in reporting his symptoms to a physician or a low index of suspicion on the part of his physicians.

In several clinics active parathyroid adenomas have been successfully removed from a number of patients in whom the diagnosis of hyperparathyroidism would have been highly questionable by older criteria. This experience not only has demonstrated that the condition is not a rare one, but has also been of great importance in delineating the clinical manifestations and diagnostic criteria justifying surgical exploration of the neck. Success in bringing effective therapy to victims of this disorder before advanced damage has developed depends upon two equally important factors: (1) recognition of the many manifestations, however mild and ill-defined, which may suggest the diagnosis, and (2) submission of patients showing these manifestations to various test procedures useful in the diagnosis and differential diagnosis of hyperparathyroidism.

The presence or passage of urinary tract stones remains the most important clue. Bone lesions, especially the early changes of the subperiosteal reabsorption in the clavicles and phalanges detected radiographically, still may be the finding first suggesting the diagnosis. More and more frequently, however, other features in the history are directing attention to the possibility of hyperparathyroidism. Especially common are gastrointestinal symptoms such as anorexia, nausea, constipation, abdominal pain, and intractable duodenal ulceration. Asthenia, weight loss, and vague complaints of ill health are very frequent, as is arterial hypertension.

When the possibility of hyperparathyroidism has been considered in a patient, he should be screened by the rather simple means now available. If there is a clear cut abnormality of the serum phosphorus or calcium concentration, an undoubted metabolic disorder exists, and the patient clearly deserves an extensive diagnostic work-up to determine the cause. These blood chemical concentrations, however, may be within normal limits in spite of the presence of active hyperparathyroidism. The most important screening test at the present time is the determination of the proportional renal tubular reabsorption of phosphorus filtered at the glomerulus. If certain simple precautions are taken, as fully described elsewhere,[1,2] and if determinations for phosphorus and creatinine in serum and urine can be made, this procedure can be carried out in the office. An abnormal value (less than 0.88) will almost always be obtained in hyperparathyroidism and in other disorders associated with elevated renal phosphorus clearance.[2] An occasional exception may occur when the serum phosphorus is very low, and some false positive tests are to be expected.

Generally speaking, studies leading to a definitive diagnosis will now depend upon whether the presenting laboratory findings are those of an elevated serum calcium concentration or of an elevated renal phosphorus clearance. Hypercalcemia may be due to many conditions other than hyperparathyroidism, such as sarcoidosis, malignant disease, vitamin D intoxication, infantile hypercalcemia, multiple myeloma, and other less common causes. Of great usefulness in differentiating these conditions is the "cortisone test," which depends upon the observation that administration of full doses of cortisone over a period of 10 days invariably results in a return of the serum calcium concentration to normal when the cause of the hypercalcemia is sarcoidosis, vitamin D intoxication, or infantile hypercalcemia, whereas the hormone is without effect upon the hypercalcemia of hyperparathyroidism. Despite the great value of this and other specialized procedures, the differential

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diagnosis of these conditions may tax the ingenuity of physicians with extensive experience with these problems.

When a low serum phosphorus concentration or a low value for proportional phosphorus reabsorption is the outstanding finding, one has to consider in the differential diagnosis all the conditions associated with a high renal phosphorus clearance, notably vitamin D-resistant rickets or osteomalacia, renal tubular acidosis and the Fanconi syndrome. A number of these conditions may closely resemble hyperparathyroidism in being manifested by urolithiasis, bone lesions, and kidney damage. If there is definite abnormality of the serum calcium concentration, the differential diagnosis is much easier, for the serum calcium tends to be high in hyperparathyroidism and low in all the other conditions mentioned. It is when the serum calcium concentration is not definitely abnormal that the greatest difficulty arises. Here, too, certain test procedures can be extremely helpful; of these, the most important is the phosphorus deprivation test. If dietary phosphorus is restricted and aluminum hydroxide, which diminishes phosphorus absorption from the bowel, is fed for a period of two weeks, the serum calcium concentration will generally rise to supernormal levels when active hyperparathyroidism is present.

With the aid of these and other procedures definitive diagnosis of early hyperparathyroidism can now be made with considerable accuracy. There is, however, no substitute for experience in the execution and interpretation of these procedures; for this reason, patients who may have hyperparathyroidism but in whom the diagnosis is not clearly apparent on the basis of the screening procedures deserve study in a center where considerable experience with the newer methods has been required. Alertness in suspecting hyperparathyroidism on the part of the general physician, surgeon, and dentist, together with a fruitful collaboration with the specialist for the definitive study of puzzling cases, can and should result in the early detection and correction of most cases of hyperparathyroidism and of the conditions with which it may be confused, some of which are equally amenable to management.

1. Hills, A. G., and Burr, J. M.: Analysis of Phosphorous Reabsorption Index: Theoretical and Practical Implications, J. Clin. Endocrinol & Metab. 17:1472-1476 (Dec.) 1957.
2. Hills, A. G., and Burr, J. M.: Hyperparathyroidism and Other Hyperphosphaturias, South. M. J. 51:465-473 (April) 1958.

A. GORMAN HILLS, M.D.
PROFESSOR OF INTERNAL MEDICINE
GEORGE D. WEBSTER JR., M.D.
ASSISTANT PROFESSOR OF MEDICINE
UNIVERSITY OF MIAMI SCHOOL OF MEDICINE

Hillsborough-Suncoast Cardiovascular Seminar Tampa, February 20-21, 1960

The Second Annual Hillsborough County and Suncoast Cardiovascular Seminar will be held Saturday and Sunday, February 20 and 21, 1960 at the Hillsboro Hotel in Tampa. Programs will be presented from 9:00 a.m. until 4:00 p.m. each day. This Seminar is jointly sponsored by the Hillsborough County Heart Association, Tampa, and the Suncoast Heart Association, St. Petersburg.

Six specialists in various phases of diagnosis, treatment, and surgery in the cardiovascular field will present lectures and take part in panel discussions, which will be held at lunch both days and at the close of each day's program.

Members of the faculty are: Dr. Samuel A. Levine, Clinical Professor of Medicine, Emeritus, Harvard Medical School, Consultant in Cardiology, Peter Bent Brigham Hospital, and Consultant Cardiologist, Newton-Wellesley Hospital, Boston; Dr. Samuel Kaplan, Assistant Professor of Pediatrics and Medicine, University of Cincinnati, College of Medicine, Cincinnati; Dr. Robert Bruce Logue, Cardiologist, Emory University Hospital, Atlanta; Dr. Richard G. Lester, Assistant Professor of Radiology, University of Minnesota Medical School, Minneapolis; Dr. Clarence Walton Lillehei, Professor of Surgery, University of Minnesota Medical School, Minneapolis; and Dr. Lawrence E. Lamb, USAF, Professor of Internal Medicine, School of Aviation Medicine, Brook Air Base, Texas.

All physicians are invited to attend by the sponsoring Heart Associations. No registration fee will be charged, but those who wish may give a donation to help defray the costs.

Florida Speakers On Annual Meeting Program

Dr. Joseph A. J. Farrington of Jacksonville, "Swimming Pool Granuloma"

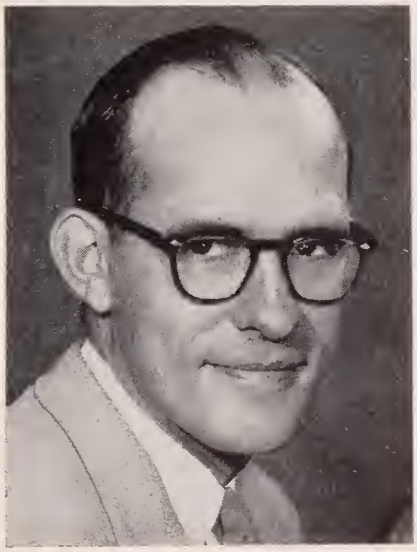
Dr. Warren Lindau of Coral Gables, "Parathion Poisoning and Treatment"

Dr. Farrington

Dr. Lindau

Dr. James D. Moody of Orlando, "Late Results in Vascular Surgery"

Dr. Curtis Cannon of Jacksonville, "A Review of 215 Cases of Invasive Carcinoma of the Cervix"



Dr. Moody

Dr. Cannon

Dr. Emmet F. Ferguson Jr. of Jacksonville, "Teamwork in Massive Bleeding Peptic Ulcer"

Dr. Albert H. Wilkinson Jr. of Jacksonville, "Thoracic and Abdominal Tumors of Infancy and Childhood."

Dr. Ferguson Jr.

Dr. Wilkinson Jr.

Seminar on Cardiovascular Diseases Jacksonville, Feb. 18-20, 1960

On Thursday, Friday and Saturday, February 18-20, the Seventh Annual Seminar on Cardiovascular Diseases will be held at the Prudential Auditorium in Jacksonville. This yearly presentation of the Northeast Florida Heart Association is accepted by the American Academy of General Practice for 15 hours' credit in Category I. The registration fee is $10, but interns, residents, medical students, and physicians in the armed services are exempt from this charge. The downtown headquarters is the Hotel George Washington, and reservations may be obtained by contacting the hotel.

The Seminar lecturers are Dr. Jesse Edwards of Rochester, Minn., Dr. Proctor Harvey of Washington, D. C., Dr. Richard P. Schmidt of Gainesville, Dr. Frank Spencer of Baltimore, Dr. James V. Warren of Galveston, and Dr. H. S. Weens of Atlanta.

There will be group luncheons in the St. Johns Room of the Prudential Building on Thursday and Friday. The annual banquet will be held on Friday night, February 19, at the Hotel George Washington.

Co-sponsors of the Seminar are the Division of Postgraduate Education of the College of Medicine of the University of Florida, the Florida Medical Association and the Florida State Board of Health.

The program follows:

SEVENTH ANNUAL CARDIOVASCULAR SEMINAR PRUDENTIAL BUILDING, JACKSONVILLE, FEBRUARY 18-20, 1960

THURSDAY, FEBRUARY 18		Presiding: Dr. Nathaniel Jones
8:30	Registration	
9:15	Words of welcome and announcements	Dr. Daniel R. Usdin
9:30	"Newer Knowledge of Congestive Heart Failure"	Dr. Warren
10:05	"Diagnosis of Congenital Heart Disease in the Adult"	Dr. Harvey
10:40	Recess	
11:00	"Functional Pathology of Occlusive Coronary Disease"	Dr. Edwards
11:30	Clinico-Pathologic Conference Moderator: Dr. C. M. Whorton	Drs. Warren, Edwards, Marvin V. McClow
12:30	Luncheon	
		Presiding: Dr. Samuel M. Day
2:00	"Use of Hypothermia in Cardiac Surgery"	Dr. Spencer
2:30	"Hyponatremic Syndrome"	Dr. Warren
3:00	Recess	
3:15	"Complications of By-Pass Operations"	Dr. Spencer
4:00	Panel: "Refractory Heart Failure" Moderator: Dr. Karl Hanson	Drs. Warren, Harvey, Spencer, Edwards
FRIDAY, FEBRUARY 19		Presiding: Dr. Lawrence E. Geeslin
9:00	"Functional Systolic Murmers"	Dr. Harvey
9:35	"Intermittent Ischemia in the Brain"	Dr. Schmidt
10:10	Recess	
10:30	"Roentgen Aspects of Pulmonary Edema"	Dr. Weens
11:05	Panel: "Indications for Various Types of Cardiac Surgery" Moderator: Dr. James E. Cousar	Drs. Spencer, Harvey, Weens, Theodore L. Batchelder
12:00	Luncheon	
		Presiding: Dr. Joseph J. Lowenthal
1:30	"Pathology and Differential Diagnosis of Chronic Myopathy"	Dr. Edwards

2:10	"Roentgen Aspects of Increased and Decreased Pulmonary Blood Flow"	Dr. Weens
2:50	Recess	
3:00	"Current Status of Anticoagulant Therapy of Strokes"	Dr. Schmidt
3:45	"Clinical Significance of Gallop Rhythm"	Dr. Harvey

SATURDAY, FEBRUARY 20 — Presiding: Dr. Russell Oppenheimer

9:00	Grand Rounds—Case Presentations Moderator: Dr. Max Michael	Drs. W. J. Taylor, Weens, Harvey, Spencer
10:15	Recess	
10:30	Questions and Answers Moderator: Dr. William M. Madison Jr.	Drs. Harvey, Spencer, Taylor, Weens, Edwards, Schmidt

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Seminar in Obstetrics and Gynecology Gainesville, February 25-26, 1960

Late this month, a Seminar in Obstetrics and Gynecology will be presented by the Department of Obstetrics and Gynecology of the College of Medicine of the University of Florida, with the assistance of the Florida State Board of Health and the Florida Medical Association. Morning sessions beginning at 9 a.m. and afternoon sessions beginning at 2 p.m. are scheduled for Thursday and Friday, February 25 and 26.

Dr. Nicholson J. Eastman, Professor of Obstetrics and Obstetrician-in-Chief, The Johns Hopkins Hospital and The Johns Hopkins University School of Medicine, Baltimore, Md., and Dr. Louis M. Hellman, Professor and Chairman, Department of Obstetrics and Gynecology, State University of New York, Downstate Medical Center, Brooklyn, N. Y., will be the guest faculty members. Eleven members of the faculty of the College of Medicine of the University of Florida will also participate in the Seminar: Drs. Victor M. Arean, Associate Professor, Department of Pathology; Julian R. Cotter, Assistant Resident, Department of Obstetrics and Gynecology; Hugh M. Hill, Assistant Professor, Department of Obstetrics and Gynecology; Andrew E. Lorincz, Assistant Professor, Department of Pediatrics; Peter F. Regan, Professor and Head, Department of Psychiatry; John D. Reeves, Professor and Head, Department of Radiology; Richard P. Schmidt, Associate Professor of Medicine, Chief of Neurology; Richard T. Smith, Professor and Head, Department of Pediatrics; Vincent G. Stenger, Assistant Resident, Department of Obstetrics and Gynecology; Charles A. Stump, Chief Resident and Instructor, Department of Obstetrics and Gynecology; and Dr. James G. Wilson, Professor and Head, Department of Anatomy.

The diversified program and the excellent faculty should attract a large attendance. The course is approved for Category I credit by the American Academy of General Practice. Address inquiries to the Division of Postgraduate Education, College of Medicine, University of Florida, Gainesville.

The New Orleans Graduate Medical Assembly

The twenty-third annual meeting of The New Orleans Graduate Medical Assembly will be held March 7, 8, 9 and 10, 1960, with headquarters at The Roosevelt Hotel.

Nineteen outstanding guest speakers will participate, and their presentations will be of interest to both specialists and general practitioners. The program will include 56 informative discussions on many topics of current medical interest, in addition to clinicopathologic conferences, symposiums, medical motion pictures, round-table luncheons and technical exhibits.

Following the meeting in New Orleans, arrangements have been made for a clinical cruise on the M/S Franca "C,, to the West Indies, leaving from Port Everglades, Fla., on Saturday, March 12. The itinerary includes visits to Puerto Rico, Virgin Islands, Martinique, Barbados, Trinidad, Curacao and Haiti, returning to Florida on Friday, March 25.

Details of the meeting and the cruise are available at the office of the Assembly, Room 103, 1430 Tulane Avenue, New Orleans 12, La.

Urologists From Southeast Meet in Jacksonville, March 13-16

Urologists from nine Southeastern states, Cuba, Puerto Rico and the Canal Zone, comprising the Southeastern Section of the American Urological Association will gather in Jacksonville on March 13-16, 1960, for their twenty-fourth annual meeting. The Hotel Robert Meyer will serve as headquarters and will also house the technical and scientific exhibits. Dr. Rudolph Bell of Thomasville, Ga., is the president of the Section, and Dr. James L. Campbell Jr. of Orlando is the secretary.

Among the nationally known guest speakers appearing on the program are Dr. Irvine H. Page of Cleveland, Professor of Medicine, Frank E. Bunts Educational Institute and Director of Research at the Cleveland Clinic Foundation, and Dr. Ferdinand Christian Helwig of Kansas City. Dr. Page will present the Ballenger Memorial Lecture, and Dr. Helwig will discuss "A Clinical-Pathological Study of Some Problems of Urological Interest."

Florida physicians presenting addresses include Dr. Peter F. Kohler of Eglin Air Force Base, "Bladder Papilloma in the Second Decade of Life;" Drs. Robert T. Braman, Russell B. Carson, W. Dotson Wells and John L. Williams of Fort Lauderdale, "Vesico-Colic Fistulae—A Study and Report of Nine Cases;" Dr. Jonas Carron of Tampa, "Lymphangioma of the Penis," and Dr. Melvin M. Simmons of Sarasota, "The Importance of the Urethral Meatus in Urologic Disease."

Two of Florida's most distinguished urologists, Dr. Robert B. McIver, a Past President of the Florida Medical Association, and Dr. E. Thomas Sellers, both of Jacksonville, will serve as honorary hosts for the meeting.

Other physicians from the state serving on various committees include:

General Arrangements Committee, Dr. William A. Van Nortwick, Jacksonville, chairman; Registration Committee, Dr. David W. Goddard, Daytona Beach, chairman, Dr. J. Harold Newman, Jacksonville; Hotel Committee, Dr. John R. Browning, Jacksonville, chairman, Dr. John S. Cowdery, Jacksonville; Reception Committee, Dr. Willard L. Fitzgerald, Miami, chairman, Dr. Russell B. Carson, Fort Lauderdale, Dr. Robert J. Brown, Jacksonville; Entertainment Committee, Dr. Robert J. Brown, Jacksonville, chairman, Dr. Frank M. Woods, Miami, Dr. James J. Nugent, Miami; Publicity Committee, Dr. John R. Browning, Jacksonville, chairman, Dr. Jack A. McKenzie, Miami, Dr. Milton M. Coplan, Miami; Golf Committee, Dr. William H. Brooks, Jacksonville, chairman; Technical Exhibits Committee, Dr. W. Dotson Wells, Fort Lauderdale, chairman, Dr. William H. Brooks, Jacksonville; Scientific Exhibits Committee, Dr. Jack Galen, Jacksonville, chairman; Motion Picture Committee, Dr. Edwin W. Brown, West Palm Beach, chairman; and Ladies Entertainment Committee, Mrs. William A. Van Nortwick, Jacksonville, chairman.

Statement to Industrial Commission On Average Fee Schedule for Workmen's Compensation Cases

In compliance with instructions of the House of Delegates of the Florida Medical Association, the Committee on Representatives to the Industrial Council completed a proposed revision of the average fee schedule for workmen's compensation and through Mr. Harry T. Gray, the Association's legal counsel, a petition was filed with the Florida Industrial Commission on June 2, 1959.

A Hearing was held before the Industrial Commission on Nov. 16, 1959 at which time Drs. Ralph W. Jack, President, Pascal G. Batson Jr., Francis T. Holland, John H. Mitchell, Lloyd J. Netto and Mr. Harry T. Gray presented conclusive statements in support of the Florida Medical Association petition. Although there was no final decision rendered at the time of the Hearing, the Commission subsequently appointed a fact-finding conference committee consisting of six representatives of industry and six physicians representing the Association. The representatives of Medicine are: Drs. Pascal G. Batson Jr., Pensacola; Leroy H. Oetjen, Leesburg; Charles Larsen Jr., Lakeland; Fred A. Butler, Tallahassee; John H. Mitchell, Jacksonville; and Francis T. Holland, Tallahassee. Representing Industry are: Sterling Turner, Chemstrand Corporation, Pensacola; John C. Lee, Associated Industries of Florida, Tallahassee; James Cameron, Winn-Dixie, Jacksonville; Ken Morefield, Associated General Contractors, Miami; and Frank G. Roche, AFL-CIO Federation of Labor, Miami Beach.

The following is a reprint of Dr. Batson's statement which was presented to the Commission at the time of the November Hearing:

The Honorable James T. Vocelle, Chairman
Florida Industrial Commission
Workmen's Compensation Division
Tallahassee, Florida

RE: Proposed Revision of the Average Fee Schedule for Workmen's Compensation. Petition Filed by the Florida Medical Association

Dear Mr. Chairman and Members of the Commission:

As the official designated representative of the Florida Medical Association, I am indeed grateful for the opportunity to appear before this Commission in support of the petition requesting revision of the average fee schedule for medical, surgical, radiological and related professional services provided for under the Florida Workmen's Compensation Act, Chapter 440, Florida Statutes. By filing such a request for revision of the fee schedule, the FMA representing 3,700 physicians respectfully petitions the Commission to exercise its fact-finding responsibility with regard to determination of the reasonableness of the proposed revised fee schedule.

With the assumption that the petitioner carries the burden of proof, we trust that the information submitted herein will assist the Commission in its final decision.

In presenting our prepared statement, we are certain there is a general consensus of agreement in that all interested parties are concerned with having the injured or diseased employee provided with the highest standard of medical service available. It is our firm belief that the concept of best medical care possible is of tripartite benefit in that it serves the worker, employer and community.

It is our further opinion that there prevails a mutual agreement that medical services are foremost in the benefits provided under the Workmen's Compensation Act. With this in mind, it is apparent that the basic adversary issue *is not* to determine which procedures used in the practice of medicine and surgery are to be considered allowable but the issue at hand is that of determination of what should be a reasonable fee in light of current dollar values and economic conditions.

It is a matter of record that the schedule currently in effect was negotiated in 1951 and was approved by the Commission to become effective October 1, 1952. Since that time there have been no changes in the schedule. In our request seeking adjustment of existing inequities regarding compensation to physicians for medical services rendered, we will attempt to confine our statements to the principal issue as previously mentioned—that being, determination of reasonable fees for medical services rendered.

The basic position of the FMA is presented thusly:

1. A physician has only his time and skill, tempered by experience to sell, and it is for this reason that each physician should receive a fee reasonably commensurate with the character, quality and extent of professional services rendered:
2. That reason is neither advanced nor shown why any physician should be expected to subsidize any portion of gainful industry by selling his services at a loss unless perhaps he so desires to exercise such an individual right or is in the course of establishing a practice;
3. That it is without propriety to assume that industrial accident cases bring to a physician's office more incidental business than private patients attract—however, it is to the exact contrary.

With regard to the latter, it should be pointed out that a most recent National Health Survey reports that 41% of injuries are home accidents, 10% motor vehicle accidents, *17% industrial accidents,* and 32% were attributable to various other types of accidents. In addition, it is reported that the 1957 national estimate indicates that more than 1,760 million dollars were spent by employers to insure or self insure their risk under workmen's compensation programs and of this amount, medical and hospital benefits amounted to an estimated $365 million. These amounts represent about 95 cents per hundred dollars ($100) of covered payroll with medical and hospitalization benefits accounting for approximately 20 cents—or on the average, half a cent per hour. (Ref. Research and Statistics, Note #39-1958 dated Nov. 18; U.S. Dept. of HEW). A comparative analysis of the Workmen's Compensation Insurance Program as furnished by the Florida Insurance Commission and as reported by the National Council of Compensation Carriers discloses the following:

Year	(1) Ratio, Compensation to Total Earned Premiums	(2) Ratio, Med. & Hosp. to Total Earned Premiums	(3) Ratio, Compensation to Total Loss Experience	(4) Ratio, Med. & Hosp. to Total Loss Experience
1952	36.27%	25.51%	58.8%	41.2%
1953	35.51	25.72	58.0	42.0
1954	34.99	26.11	57.2	42.8
1955	34.91	27.09	56.3	43.7
1956	31.51	25.03	55.8	44.2
Median Ratio	(34.99)	(25.72)	(57.2)	(42.8)

It is of significance to note that the percentage ratios for both Compensation and Medical Experience to Total Loss Experience and to Total Earned Premiums have remained relatively constant—varying only 1% to 2% per year. At the time of preparation of this statement, medical and hospital frequency data as pertaining to the Florida Workmen's Compensation Program were not available; therefore, it would be illogical to attempt to comment as to what percentage increase costwise the proposed revised schedule would occasion. It is accepted that any increase in the schedule, if so granted, would occasion an increase in the cost of the program; however, we are cognizant that the Commission's principal concern in considering this petition is that of determining reasonableness of fees for medical services.

To allude further regarding increased costs, attention is invited to consideration of not only expected increased costs as may be applied to the Workmen's Compensation Program but also those increases in the cost of living as evidenced by the Consumer Price Index, wages and salaries, and the cost of drugs, materials, and supplies. The economic position of the physician engaged in the private practice of medicine is summarized by a constituent medical society report which points out that:

> "In maintaining a practice the physician provides facilities, equipment and supplies in office or clinic enclosure. He maintains and operates these with all the attendant fiscal responsibilities. Wages, salaries and other incidental expenses must be paid to his various and sometimes varied personnel. After first satisfying these demands, his net income may then be computed. Therefrom, he satisfies his living expenses."

In addition, reference is made to the statement made by the actuarial firm of Coates, Heffruth and England which reads in part:

> "As self-employed individuals, physicians are not paid a wage. In lieu of wages they receive their compensation by means of the fees they charge. Therefore, their compensation is directly related to their fees just as an employed individual's compensation is directly related to his wages."

The physician's practice, like any other professional practice or business, does not elude the economic factor of increased costs of doing business. Recent reports of the U. S. Department of Labor, Bureau of Statistics, show that between 1950 and 1959 the cost of living rose 25.2%. Additional statistical reports as contained in the *Monthly Labor Review* published by the U. S. Department of Labor indicate that gross average weekly earnings of production workers increased from $66.91 in 1952 to $83.50 in 1958 or an increase of approximately 25%. *Florida Employment Statistics,* a publication of the Florida Industrial Commission, shows that average weekly earnings increased from $58.23 in 1954 to $74.62 in 1959. This represents a percentage increase of 28%. As further example, the State of Florida has experienced notable increases in wages and salaries of professional personnel employed by various state agencies. The following table shows the monthly salary in the top grade for several State of Florida classifications of professional personnel. The salary in 1951 and the salary today are shown, along with the percentage increase:

Classification		Top Monthly Salary 1951	Top Monthly Salary Today	Percentage Increase
1. Health Officer	I	$550.	$ 760.	38%
	II	650.	960.	48
	III	725.	1050.	45
	IV	825.	1150.	39
			Average	43%
2. Public Health Nurse	I	245.	345.	41
	II	290.	400.	34
	III	345.	460.	33
	IV	400.	525.	31
	V	475.	630.	33
			Average	34%
3. Physical Therapist		250.	420.	68%
4. X-Ray Technician	I	210.	270.	29
	II	290.	345.	19
	III	370.	420.	14
			Average	27%

The above table indicates that the state has experienced an overall average increase of 43% in salaries for professional personnel during the period 1951 to 1959.

We urge that it be understood that the petition request relates only to physician's fees and does not involve hospital services and other medical benefits. Let it be emphasized that hospital services, drugs, appliances, etc., are compensated for at the current market price and are not limited to a fixed schedule. Therefore, it appears unjust to expect that physician services should be provided and continue to be compensated for on the basis of a limited schedule which was put into effect in 1952. The Consumer Price Index for the period Sept. 1952—June 1959 indicates that Physicians' Fees increased 28.3 points or 25% while Hospital rates increased 68.0 points or 48%. The increase in hospital rates has been absorbed in payments for hospital services while compensation for physician services has remained constant because of a limited and restricted fee schedule. It is of further significance to note that the Consumer Price Index also indicates that the big bite out of employee earnings and family income has not gone for increased physicians fees but for other items such as increased taxes, automobile insurance rates, transportation services and other commodities.

In view of the increased costs of living which have occurred since the effective date of the current schedule, it is felt that the proposed fee schedule would be an attempt to reasonably adjust physicians' fees in light of today's economy. Should the Commission adopt the proposed schedule, it would still result in fees somewhat less than the usual fees charged by physicians in the State of Florida for private patients.

In summary, the proposed schedule under consideration in no small way represents the accomplishment of a menial task. The respective committee of the FMA has attempted to develop a complete and comprehensive fee schedule and one which is representative of average fees charged. The revised schedule was developed through the use of Relative Value Studies and is designed not only to adjust fees for certain medical procedures but it is also intended to accomplish several objectives which should prove to be of future benefit in administering that portion of the Workmen's Compensation Program concerned with medical services. Through the use of relative values it was possible to develop a schedule which adequately reflects the equitable value for the various medical procedures listed. From proven experience there are obvious and numerous irregularities in the existing schedule. Such irregularities and inadequacies are attributable primarily to the arbitrary assignment of allowable fees and the limited listing of procedures. It is expected that this comprehensive schedule will prove to be of benefit in that it will reduce those instances where misunderstanding often develops between physician and insurance carrier when considering professional services that are to be provided on an agreed and arranged basis. In addition, it should undoubtedly assist insurance companies in establishing indemnity schedules. At the same time such a schedule would remain sufficiently flexible in order to provide a means for individual consideration for any unusual circumstance. It is without question that the medical profession, having professional knowledge of the relative values of the procedures utilized in the practice of medicine and surgery, is in the unique position of being the only group professionally qualified to determine the relation of one procedure to another. Obviously, it would be as much a fallacy for physicians to attempt to establish insurance rates, utility rates, hospital rates, and other commodity prices as it would be for anyone not professionally qualified to attempt to establish fees for professional services. Any schedule developed without the benefit of professional advice would be totally unacceptable to physicians.

In closing, it might be added that it would be impractical to present in this statement a lengthy dissertation regarding the use of Relative Value Studies in establishing the proposed fee schedule. However, it was possible to develop through the use of relative values a proposed revision of the average fee schedule which is complete and comprehensive. Should the Commission see fit to adopt the revised schedule, it would be a step forward in establishing a means whereby future adjustments could be made realistically with a minimum of effort. Previous actions of the Commission have noted that a physician should receive a fee commensurate with the character, quality and extent of professional services rendered Therefore, it is submitted that in the opinion of the petitioners, the revised schedule is fair, reasonable, and deserving of consideration.

At the pleasure of the Commission we would be most pleased to discuss orally any of the points

presented in this statement and to answer questions that may arise regarding the subject.

Sincerely,

P. G. BASTON JR., M.D., *Chairman FMA Committee on Representatives to the Industrial Council*

American Medical Association Thirteenth Clinical Meeting Report of Delegates

Freedom of choice of physician, relations between physicians and hospitals, a scholarship program for deserving medical students and relative value studies of medical services were among the major subjects acted upon by the House of Delegates at the American Medical Association's Thirteenth Clinical Meeting held December 1-4, 1959 in Dallas.

Dr. Chesley M. Martin of Elgin, Okla., was named as the 1959 General Practitioner of the Year for his outstanding contributions to the health and civic affairs of his home community. Dr. Martin, who has practiced in Elgin for the past 44 years, was the thirteenth recipient of the annual award and the first Oklahoman to be so honored.

Speaking at the Tuesday opening session of the House of Delegates, Dr. Louis M. Orr of Orlando, President of the American Medical Association, urged the nation's physicians to take a more active interest in the whole area of politics, public affairs and community life. Dr. Orr also asked physicians and medical societies to do a more effective job of telling medicine's positive story, adding that "if more people knew more about the things we support and encourage, they would listen to us much more carefully about those occasional things that we oppose."

Two nationally known political leaders from Texas also addressed the Tuesday morning session. Senator Lyndon B. Johnson, majority leader in the United States Senate, called for a "politics of unity" which will enable Americans to exert strength and determination in an effort to create a world in which all men can be free. Speaker of the United States House of Representatives Sam Rayburn urged greater attention to the task of educating young people in the principles of American government and giving them a desire to perpetuate it.

Total registration reached 5,827, including 2,817 physicians, residents and interns.

Freedom of Choice

In considering four resolutions which in various ways would have changed or replaced the statements on freedom of choice of physician which the House adopted in June 1959, when acting upon the recommendations in the report of the Commission on Medical Care Plans, the House reaffirmed the following two statements approved in Atlantic City:

1. "The American Medical Association believes that free choice of physician is the right of every individual and one which he should be free to exercise as he chooses.
2. "Each individual should be accorded the privilege to select and change his physician at will or to select his preferred system of medical care, and the American Medical Association vigorously supports the right of the individual to choose between these alternatives."

In order, however, to clarify and strengthen its position on the issue of freedom of choice of physician, the House also adopted this additional statement which was submitted as a substitute amendment on the floor of the House:

3. "Lest there be any misinterpretation, we state unequivocally that the American Medical Association firmly subscribes to freedom of choice of physician and free competition among physicians as being prerequisites to optimal medical care. The benefits of any system which provides medical care must be judged on the degree to which it allows of, or abridges, such freedom of choice and such competition."

Physician—Hospital Relations

The House received 12 resolutions on the subject of relationships between physicians and hospitals. To resolve any doubt about its position, the House did not act upon any of the resolutions, but instead reaffirmed the 1951 "Guides for Conduct of Physicians in Relationships with Institutions." It also declared that "all subsequent or inconsistent actions are considered superceded." The House also accepted recommendations that (1) the House of Delegates acknowledge the need to strengthen relationships with hospitals by action at state and local levels, (2) the Board of Trustees of the Association continue to maintain liaison with the Board of Trustees of the American Hospital Association, and (3) the Council on Medical Service review this entire problem to ascertain if there have been actions inconsistent with the 1951 Guides.

Those Guides summarize the following general principles as a basis for adjusting controversies:

"1. A physican should not dispose of his professional attainments or services to any hospital, corporation or lay

body by whatever name called or however organized under terms or conditions which permit the sale of the services of that physician by such agency for a fee.

"2. Where a hospital is not selling the services of a physician, the financial arrangement if any between the hospital and the physician properly may be placed on any mutually satisfactory basis. This refers to the remuneration of a physician for teaching or research or charitable services or the like. Corporations or other lay bodies properly may provide such services and employ or otherwise engage doctors for those purposes.

"3. The practice of anesthesiology, pathology, physical medicine and radiology are an integral part of the practice of medicine in the same category as the practice of surgery, internal medicine or any other designated field of medicine."

Scholarship Program

To help meet the need for an increasing number of physicians in the future, the House approved the creation of a special study committee which was asked to:

1. Present a scholarship program, its development, administration and the role of the American Medical Association in fulfilling it.
2. Ascertain the maximum to which medical schools could expand their student bodies while maintaining the quality of medical education.
3. Ascertain what universities can support new medical schools with qualified students and sufficient clinical material for teaching, either on a two year or a full four year basis.
4. Investigate the securing of competent medical faculties.
5. Investigate financing of expansion and establishment of medical schools.
6. Investigate financing of medical education as to the most economical methods of obtaining high quality medical training.
7. Develop methods of getting well qualified students to undertake the study of medicine.
8. Investigate the possibility of relaxing rigid geographic restrictions on the admission of students to medical schools.

The House urged that the special committee be implemented promptly with adequate funds and staff so that it may make an initial report by June 1960.

Relative Value Studies

Reaffirming a previous policy statement, the House approved in principle the conducting of relative value studies by each state medical society, rather than a nationwide study or a series of regional studies by the American Medical Association. The House also reiterated its authorization for the Committee on Medical Practices to inform each state medical association, through regional or other meetings, of the purpose, scope and objectives of such studies, the steps to be followed in conducting studies, the problems which may be encountered and the manner in which the results can be applied.

The House recognized, however, that some state medical societies are either not interested in relative value studies or are actively opposed to them. It pointed out that some state medical associations fear that the regional conferences of the Committee on Medical Practices will put pressure on them to carry out such studies and that this will result in the adoption of "fixed fees." Since the regional conferences are educational in nature, the House said, it remains for each state or county medical association to accept or reject the idea of a study in its area. The House expressed awareness of the fact that this is still a controversial matter. It, however, commended the Committee on Medical Practices for its effort to carry out the instructions of the House, and it urged the committee to continue its educational work.

Miscellaneous Actions

In considering 44 resolutions and a large volume of annual, supplementary and special reports, the House also:

Learned that the Board of Trustees of the American Medical Association has appointed a liaison committee to meet with a similar committee of the American Osteopathic Association to consider matters of common concern;

Emphasized that local medical societies should insure that no member violates ethical traditions as they relate to ownership of pharmacies or stock in pharmaceutical companies;

Approved the plan of the Committee on Medical Rating of Physical Impairment to publish its new guide on the cardiovascular system in the Journal of the American Medical Association;

Called for investigation of the need, desirability and feasibility of establishing a home for aged and retired physicians;

Urged active promotion and careful study of the newly developed "Guides for Medical Care in Nursing Homes and Related Facilities;"

Suggested that fees for consultative examinations under programs of the Bureau of Old Age and Survivors Insurance should be adjudicated directly between the state medical society and the state agency involved;

Registered a strong protest to the Veterans Administration, urging stricter screening of non-service-connected disability patients admitted to government hospitals;

Reiterated the Association's support of the Blue Shield concept and directed the Council on Medical Service to submit at the June 1960 meeting its recommendations concerning a policy

statement on American Medical Association relationship with Blue Shield plans;

Suggested that S. J. Res. 41, a bill which would institute a separate program of international medical research, be delayed until an over-all assessment can be made of proposals now before the Congress dealing with domestic and international medical research;

Endorsed the program of the Educational Council for Foreign Medical Graduates, but also urged that judicious consideration be given to local problems involved in the July 1, 1960, deadline for certification of foreign graduates;

Urged that medical schools include in their curricula a course on the social, political and economic aspects of medicine;

Declared that the threat of nuclear warfare has imposed a tremendous responsibility on the medical profession, which must be prepared to assume a critically important role in such an event;

Suggested that the American Medical Association make available to school libraries information and literature showing the advantages of private medical care and the American free enterprise system;

Stated that examinations to determine the physical and mental fitness of aircraft crew members should be made by doctors of medicine with special knowledge and proficiency in certain techniques;

Urged the American people to get proper tetanus toxoid, original and booster, and other immunizations as indicated from their physicians, and called on members of the American Medical Association to cooperate in an educational program on tetanus immunization;

Recommended that all state and county medical societies establish programs for the inspection and testing of all fluoroscopes and radiographic equipment;

Called upon each individual physician to wage "a vigorous, dynamic and uncompromising fight" against the Forand type of legislation;

Urged state and local medical societies and individual physicians to implement the American Medical Association's program for recruitment of high grade medical students;

Accepted with appreciation a $2,500 contribution by Smith, Kline and French Laboratories toward establishment of a suitable award honoring the name of Dr. Thomas G. Hull, retiring secretary of the Council on Scientific Assembly, and

Reaffirmed the "Suggested Guides to Relations Between Medical Societies and Voluntary Health Agencies," which were adopted at the December 1957 meeting in Philadelphia.

At the Tuesday opening session, six state medical societies presented nearly $250,000 to the American Medical Education Foundation. The checks turned over to Dr. George F. Lull, president of the Foundation, were: California, $156,-562; Indiana, $35,570; New York, $19,546; Utah, $10,355; New Jersey, $10,000, and Arizona, $9,263.

Respectfully submitted,

Reuben B. Chrisman Jr., M.D., Chairman
Francis T. Holland, M.D.
Meredith Mallory, M.D.
Burns A. Dobbins Jr., M.D.

Registration

CORAL GABLES: Reuben B. Chrisman, Jr. FORT LAUDERDALE: Russell B. Carson, Burns A. Dobbins, Jr. JACKSONVILLE: Frank G. Long, Paul V. Reinartz. LAKE WORTH: Alvah L. Rowe. LANTANA: Maurice Kovnat. MIAMI: Ralph W. Jack, Homer L. Pearson, Walter W. Sackett, Ralph S. Sappenfield, Louis J. Wisch. ORLANDO: Meredith Mallory, Louis M. Orr. PENSACOLA: Robert N. Price. ST. PETERSBURG: Paul F. Wallace. TALLAHASSEE: Francis T. Holland. TAMPA: Lee J. Cordrey, H. Phillip Hampton. VERO BEACH: Erasmus B. Hardee. WEST PALM BEACH: Theodore Norley.

Conference Announcing Activities College of Health Related Services And Rehabilitation Area J. Hillis Miller Health Center

A conference to announce formally the activities of the College of Health Related Services and the Rehabilitation Area is scheduled for the University of Florida's J. Hillis Miller Health Center on February 5 and 6, 1960.

Scheduled to participate in the two day series of panels, lectures and conference are Miss Mary Switzer, Director of the Federal Office of Vocational Rehabilitation; Dr. Howard A. Rusk, Director of the Institute of Physical Medicine and Rehabilitation at New York University; and Dr. Alfred Shands, Medical Director of the Nemours Foundation.

Saturday morning, Grand Rounds will be conducted in the Teaching Hospital and Clinics by Dr. Rusk. Visiting physicians are invited to all sessions.

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for rapid relief of anxiety manifestations

You will find Dartal outstandingly beneficial in management of the anxiety-tension states so frequent in hypertensive or menopausal patients. And Dartal is particularly useful in the treatment of anxiety associated with cardiovascular or gastrointestinal disease, or the tension experienced by the obese patient on restricted diet. You can expect consistent results with Dartal in general office practice.

with low dosage: Only one 2, 5 or 10 mg. tablet t.i.d. *with relative safety:* Evidence indicates Dartal is not icterogenic.

Clinical reports on Dartal: 1. Edisen, C. B., and Samuels, A. S.: A.M.A. Arch. Neurol. & Psychiat. *80*:481 (Oct.) 1958. 2. Ferrand, P. T.: Minnesota Med. *41*:853 (Dec.) 1958. 3. Mathews, F. P.: Am. J. Psychiat. *114*:1034 (May) 1958.

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The first synthetic penicillin
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for general clinical use

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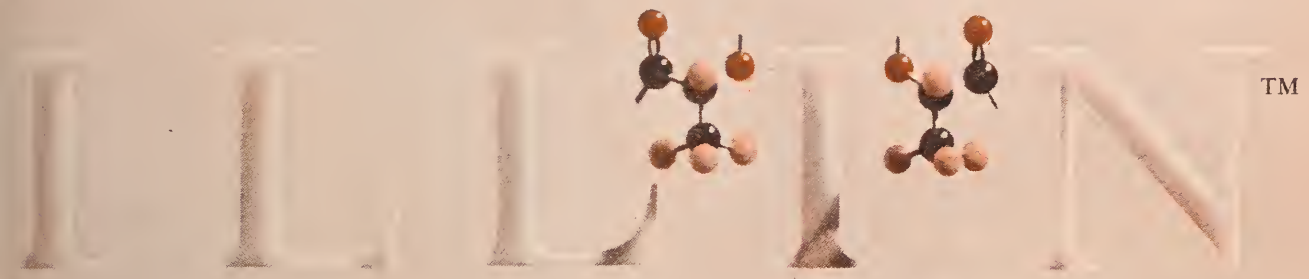
BLOOD LEVELS TWICE AS HIGH AS WITH POTASSIUM PENICILLIN V

ORAL ROUTE PROVIDES HIGHER BLOOD LEVELS THAN INTRAMUSCULAR PENICILLIN G

IMPROVED ANTIBIOTIC ACTION FROM ISOMERIC COMPLEMENTARITY

CONSIDER THESE 6 IMPORTANT THERAPEUTIC BENEFITS OF



POTASSIUM PENICILLIN-152

ANTIBIOTIC ACTIVITY DIRECTLY PROPORTIONAL TO ORAL DOSE

REDUCED RATE OF INACTIVATION BY STAPH PENICILLINASE

MANY STAPH STRAINS MORE SENSITIVE TO SYNCILLIN IN VITRO

BRISTOL

FOR HIGHLY EFFECTIVE THERAPY OF THE LARGE VARIETY OF INFECTIONS CAUSED BY SUSCEPTIBLE PATHOGENS...NEW

SYNC

Significance of complementary action of isomers in SYNCILLIN

The antibiotic effect of the clinically available mixture, SYNCILLIN, is greater than that of either of its two component isomers alone against many important pathogens, including some penicillin-resistant staphylococci. This phenomenon has been described as *Isomeric Complementarity*.

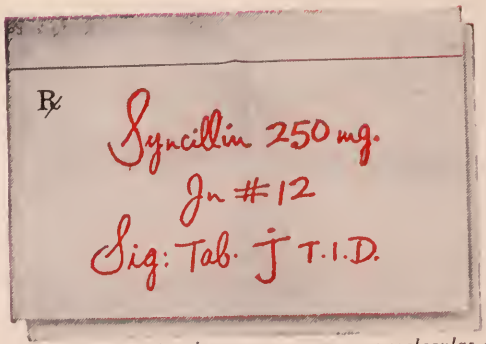
Significance of higher blood levels with SYNCILLIN

Higher blood levels may be of value with organisms of only moderate penicillin sensitivity where doubling the blood concentration may be essential for effective bactericidal action. In addition, these higher levels may be necessary where there is infection in areas with a poor blood supply.[6] Under these circumstances a higher blood concentration may provide the increased diffusion pressure required to deliver adequate amounts to the tissue. Also, antibiotic activity of SYNCILLIN is directly proportional to oral dosage. Increasing the dosage may, therefore, enhance the drug's effectiveness in certain cases.

Efficacy of SYNCILLIN against staphylococci and other resistant organisms

Studies have shown that SYNCILLIN is effective *in vitro* against 60 to 75% of hospital "staph" strains, while penicillin G and penicillin V are now effective against only 30 to 50%.[1, 2] Therefore, if clinical judgment indicates the use of penicillin, SYNCILLIN would be expected to be the most effective. However, since some strains are still resistant to SYNCILLIN as well as to the other penicillins, cultures and sensitivity tests should be performed where indicated by clinical judgment.

There have recently been reports of decreased efficacy of penicillin in streptococcal[3] and gonococcal[4, 5] infections. The emergence of penicillin-resistant gonococci appears to be associated with an increase in the incidence of gonorrhea all over the world. When a less sensitive strain is encountered the higher blood levels produced by SYNCILLIN may be most helpful.



major therapeutic advantages accompany molecular asymmetry

LLIN™

Relation of intermittent gh blood levels SYNCILLIN o antibacterial efficacy

SYNCILLIN, like all clinically available penicillins, is bactericidal. Periodic high blood concentrations are sufficient to permit complete eradication of sensitive pathogens. Continuous high blood levels are not required with SYNCILLIN. According to Eagle,[7] "Soon after penicillin attains effective concentrations, the bacteria cease multiplying; and the bacteriostatic effect persists for a number of hours after penicillin has fallen to concentrations that are wholly ineffective....The therapeutic significance of this postpenicillin recovery period is enhanced by the fact that the recovering bacteria, damaged but not killed by the previous exposure to penicillin, are abnormally susceptible to the host defenses. In consequence, the bactericidal process *in vivo* continues for many hours after the drug itself has fallen to ineffective concentrations."

Reduced rate of inactivation SYNCILLIN by staph penicillinase

Bacterial resistance to penicillin has been attributed to the action of penicillin-inactivating enzymes produced by the invading organisms. SYNCILLIN is less affected by staphylococcal penicillinase than either of its component isomers. Further, SYNCILLIN is shown to be less inactivated by this enzyme than penicillin V and penicillin G. Penicillinase from *B. cereus* likewise inactivates SYNCILLIN less rapidly than penicillin V and G. But this would not impede the therapeutic use of this penicillinase in allergic reactions. This is because the massive dosage with which this enzyme is administered would effectively destroy SYNCILLIN in the body.

References: 1. Wright, W. W.: Microbiology Report to Bristol Laboratories Inc. 2. Kligman, A.; Morigi, E. M. E.; Wheatley, W. B., and Albright, H.: Paper presented at the Seventh Antibiotic Symposium, November 4-6, Washington, D.C. 3. Editorial: New England J. Med. **261**:305 (Aug. 6) 1959. 4. King, A.: Lancet **1**:651 (March 29) 1958. 5. Epstein, E.: J.A.M.A. **169**:1055 (March 7) 1959. 6. Kass, E. H.: Am. J. Med. **18**:764 (May) 1955. 7. Eagle, H.: J. Bact. **58**:475, 1949.

Indications: SYNCILLIN is recommended in the treatment of infections caused by pneumococci, streptococci, gonococci, corynebacteria, and penicillin-sensitive staphylococci. In addition, SYNCILLIN is effective against certain strains of staphylococci resistant to other penicillins. SYNCILLIN, like other oral penicillins, is not recommended at the present time in deep-seated or chronic infections, subacute bacterial endocarditis, meningitis, or syphilis.

Dosage: 125 mg. or 250 mg. three times daily, depending on the severity of infection. Larger doses (e.g., 500 mg. t.i.d.) may be used for more severe infections. SYNCILLIN may be administered without regard to meals. Beta hemolytic streptococcal infections should be treated with SYNCILLIN for at least ten days.

Precautions: At the present time it is not possible to draw definite conclusions regarding the incidence of allergenicity to SYNCILLIN or its cross-allergenicity with natural penicillins. *Therefore, the usual precautions for oral penicillin therapy should always be observed.* Patients with histories of asthma, hay fever, urticaria, or previous reactions to penicillin should be watched with special care. Administration of oral penicillin, in rare instances, may provoke acute anaphylaxis, particularly in penicillin-sensitive individuals.
Diarrhea has been reported occasionally following heavy dosage. If this occurs, lengthen the interval between dosages.
If superinfection occurs during therapy, appropriate measures should be taken. Since some strains of staphylococci are resistant to SYNCILLIN as well as to other penicillins, cultures and sensitivity tests should be performed where indicated by clinical judgment. As is true with all antibiotics, clinical response does not always correlate with laboratory bacterial sensitivity reports.

Supply: 125 and 250 mg. tablets, bottles of 25 and 100. 125 mg. powder for oral solution, 60 ml. vials.

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when the
rheumatic
disorder
is more
than salicylates
alone
can control...

MORE
HIGHLY INDIVIDUALIZED
THERAPY
FOR THE
RHEUMATIC
"IN-BETWEEN"

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requires
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inten
steroid ther
a

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wider latitude in adjusting dosage

ARISTOGESIC is particularly effective for relief of chronic — but less severe — pain of rheumatic origin. ARISTOGESIC combines the anti-inflammatory effects of ARISTOCORT® Triamcinolone with the analgesic action of salicylamide, a highly potent salicylate. Dosage requirements for ARISTOGESIC are substantially lower than generally required for each agent alone. The exceptionally wide latitude of dosage adjustment with ARISTOGESIC permits well-tolerated therapy for long periods of time with fewer side effects.

Indications: Mild cases of rheumatoid arthritis, tenosynovitis, synovitis, bursitis, mild spondylitis, myositis, fibrositis, neuritis, and certain muscular strains.

Dosage: Average initial dosage: 2 capsules 3 or 4 times daily. Maintenance dosage to be adjusted according to response.

Precautions: All precautions and contraindications traditional to corticosteroid therapy should be observed. The amount of drug used should be carefully adjusted to the lowest dosage which will suppress symptoms. Discontinuance of therapy must be carried out gradually after patients have been on steroids for prolonged periods.

Each ARISTOGESIC Capsule contains:

ARISTOCORT® Triamcinolone	0.5 mg.
Salicylamide	325 mg.
Dried Aluminum Hydroxide Gel	75 mg.
Ascorbic Acid	20 mg.

Supply: Bottles of 100 and 1,000.

gesic® Capsules

Steroid-Analgesic Compound LEDERLE

Lederle

ERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

OTHERS ARE SAYING

Faith, Hope and Charity

Recently another meaning of Faith, Hope and Charity as it pertains to the doctor-patient-consultant relationship was impressed upon me. Too often we go about our daily tasks somewhat calloused to the suffering physically and mentally that surrounds us. It is true that to think clearly we all must attempt to be impersonal during critical periods, but too often our best efforts are criticized by our patient's bereaved relatives because of this impersonally scientific attitude.

A short while ago I had occasion to experience and to observe a skilled consultant that I called in to see a critically ill patient. I was assuredly aware of the faith that the family had in me and the hope that they clung to that I could reverse the 'tide' but I wondered whether I had overlooked something in my therapy of the patient since despite the use of all of the therapeutic efforts known to me, my patient was following a downhill course. The lesson I learned was graciousness which is a form of charity—not as we ordinarily speak of charity, but of charitableness. The consultant was gracious and understanding of me, the patient, and of all the relatives including the children concerned. He was gracious in that he gave willingly of his time, his knowledge, his heart and his assurance. He offered hope even though it was slim, and when he left I felt he had helped me; the family's faith in our efforts was even greater than before. Their hope was measurably increased and I am certain they felt that they had been treated with charitable graciousness and that we were doing all in our power to help not only the patient but them, too, during their 'hour' of bereavement. Permit me to encroach a little more on your valuable time and let me ask you to stop here and go back to the beginning of this paragraph, to read it more slowly and thoughtfully once again, and then to indelibly imprint this in your mind. Never forget it and there will never be a need for socialization of medicine or law suits or some of the other unpleasantries that are basically criticisms from our patients and their relatives.

Miles J. Bielek, M.D.
The Record
Broward County Medical Association
April 1959

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Diagnostic Quandaries

Colitis? Gall Bladder Disease?
Chronic Appendicitis?
Rheumatoid Arthritis? Regional Enteritis?

A DISEASE that is frequently overlooked in solving diagnostic quandaries is amebiasis. Its symptoms are varied and contradictory, and diagnosis is extremely difficult. In one study, 56% of the cases would have been overlooked if the routine three stool specimens had been relied on.[1]

Another study found 96% of a group of 150 patients with rheumatoid arthritis were infected by *E. histolytica*. In 15 of these subjects, nine stool specimens were required to establish the diagnosis.[2]

Webster discovered amebic infection in 147 cases with prior diagnoses of spastic colon, psychoneurosis, gall bladder disease, nervous indigestion, chronic appendicitis, and other diseases. Duration of symptoms varied from one week to over 30 years. In some cases, it took as many as six stool specimens to establish the diagnosis of amebiasis.[3]

Now treatment with Glarubin provides a means of differential diagnosis in suspected cases of amebiasis. Glarubin, a crystalline glycoside obtained from the fruit of *Simarouba glauca*, is a safe, effective amebicide. It contains no arsenic, bismuth, or iodine. Its virtual freedom from toxicity makes it practical to treat suspected cases without undertaking difficult, and frequently undependable, stool analyses. Marked improvement following administration of Glarubin indicates pathologically significant amebic infection.

Glarubin is administered orally in tablet form and does not require strict medical supervision or hospitalization. Extensive clinical trials prove it highly effective in intestinal amebiasis.

Glarubin*

TABLETS

specific for intestinal amebiasis

Supplied in bottles of 40 tablets, each tablet containing 50 mg. of glaucarubin.

Write for descriptive literature, bibliography, and dosage schedules.

1. Cook, J.E., Briggs, G.W., and Hindley, F.W.: Chronic Amebiasis and the Need for a Diagnostic Profile, Am. Pract. and Dig. of Treat. 6:1821 (Dec., 1955)

2. Rinehart, R.E., and Marcus, H.: Incidence of Amebiasis in Healthy Individuals, Clinic Patients and Those with Rheumatoid Arthritis, Northwest Med., 54:708 (July, 1955)

3. Webster, B.H.: Amebiasis, a Disease of Multiple Manifestations, Am. Pract. and Dig. of Treat. 9:897 (June, 1958).

*U.S. Pat. No. 2,864,745

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BLUE SHIELD

Supplements to Basic Coverage

As youthful and promising as the new year are two additions to the Blue Shield family. To be known as Master Medical and Extended Benefits Endorsements, these fledglings will offer supplementary benefits to basic Blue Shield coverage. As Endorsements they will be available only as additions to a basic contract, and only in conjunction with a companion Blue Cross Endorsement. Now, it becomes possible for group subscribers, through one of these Endorsements, to avail themselves of still greater protection without sacrificing the advantages of service benefits and community rating.

In the deluge of health insurance programs that have descended upon the public since Blue Shield pioneered in providing prepayment methods for budgeting expenses for professional services, physicians must continue to keep in mind that it was they who had sufficient courage to step into this untried field in the beginning. This venture was in the face of conviction by the insurance industry that protection against the costs of illness was unpractical and economically unsound, and that the principles of service benefits and community rating were the sheerest of folly. Blue Shield is still the doctors' program and continues to lead the field. The addition of Master Medical and Extended Benefits is proof positive of determination to continue being the pace setters.

One vital factor which must not become obscured is that any program for protection against the cost of illness, whether it be nonprofit service benefit or commercial indemnity, whether it be voluntary or compulsory, is dependent upon the cooperation, integrity and compassion of individual physicians. Doctors must also keep in mind that they first sponsored this movement in response to a pressing need and insistent demand from the public. It is certain that this same public will continue to look to the medical profession for leadership and guidance in all phases of health care and health care benefits.

Now, once again, the service plans in Florida are supplying a need which is being demanded by a health-conscious public. There is insistence

(Continued on page 1002)

ANNOUNCING SCHERING'S NEW MYOGESIC[X]

RELA™ X

CARISOPRODOL

–EASES MUSCLE SPASM & PAIN IN SPRAINS, STRAINS, LOW BACK PAINS

[X]MYOGESIC
muscle relaxant – analgesic

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NIAMID
the mood brightener

makes the cancer patient more comfortable

- reduces impact of pain
- decreases narcotic requirements
- increases appetite
- improves mental outlook

NIAMID lessens the need for narcotics in the depressed cancer patient and appears to potentiate pain-relieving agents. As pain is reduced and mental outlook improves, apprehension and depression are replaced by a brighter and more alert attitude, and appetite returns. The family, too, is cheered by the improvement in the patient's condition. With NIAMID therapy, patient care becomes noticeably less demanding.

Supply: NIAMID (brand of nialamide) is available as 25 mg. (pink) and 100 mg. (orange) scored tablets.

Complete references and a Professional Information Booklet giving detailed information on NIAMID are available on request from the Medical Department, Pfizer Laboratories, Division, Chas. Pfizer & Co., Inc., Brooklyn 6, New York

NIAMID®
the mood brightener in cancer

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Science for the world's well-being™

ANNOUNCING
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MYOGESIC[X]

RELA™
CARISOPRODOL

EASES STRAINS
SPRAINS & LOW
BACK PAINS...!

X

RELA—a new myogesic for better relaxant *and* analgesic therapy—more adept management of spasm and pain in strains, sprains and low back pains.

RELA—though a single drug—is a true myogesic and works rapidly to achieve three desired effects...

Rela relaxes acute muscle spasm
Relief of muscle spasm (96% excellent to good effectiveness)[1]

Rela provides a unique quality of persistent pain relief through its relaxant and analgesic actions
"Relief from pain was usually rapid and sometimes dramatic"[1]

Rela, through relaxation and analgesia, assures daytime ease and nighttime rest
"... A number of patients reported freedom from insomnia which they attributed to freedom from pain."[1]

indications: RELA is most beneficial in those conditions of the musculoskeletal system manifesting pain, stiffness and spasm.

safety: Studies of more than 1400 patients indicate that the toxicity of RELA is exceptionally low. In human subjects, respiratory, blood pressure or blood chemistry changes and/or renal, hepatic or endocrine dysfunction have not been reported.

dosage: The usual adult dosage of RELA is one tablet 3 times daily and at bedtime. RELA has a rapid onset of action, with relief usually apparent within 30 minutes, and persisting for at least 6 hours.

supply: RELA is available as 350 mg., pink, coated tablets in bottles of 30.

1. Kuge, T: To be published.

MYOGESIC
muscle relaxant analgesic

Schering

Whenever the diet is faulty, the appetite poor, or the loss of food is excessive

through vomiting or diarrhea—

Valentine's
MEAT EXTRACT

stimulates the appetite,
increases the flow of digestive juices,
provides: supplementary amounts of vitamins, minerals and soluble proteins,
extra-dietary vitamin B_{12},
protective quantities of potassium, in a palatable and readily assimilated form.

Supplied in bottles of 2 or 6 fluidounces.

Dosage *is 1 teaspoonful two or three times daily; two or three times this amount for potassium therapy.*

VALENTINE Company, Inc.
RICHMOND 21, VIRGINIA

(Continued from page 998)

that, although the basic Blue Shield–Blue Cross combined protection is the best that has been available, it is no longer adequate. Understandably, there is an earnest and sincere desire to be protected against the bankrupting costs of extended illness. Through Master Medical and Extended Benefits Endorsements such protection is now available to group subscribers.

The Endorsement of Extended Benefits is well named. It extends, for an unlimited period, up to a maximum dollar utilization, the coverage specified in the Basic Contracts. A limited number of benefits have been added on a coinsurance basis. No deductibles are involved other than such as may be contained in the Basic Contracts. It is truly an extension, a stretching out of benefits to provide for long term illness. Master Medical, on the other hand, tends to surround the basic program with extended and supplemental benefits. Since this is comprehensive coverage with relatively high limits, the control provisions of deductibles and coinsurance are incorporated. It is a "corridor" type of deductible. That is, it is applied after the subscriber has received the benefits provided by the Basic Contracts.

Offering these additional benefits is evidence that Blue Shield intends to continue to grow and to meet the needs of its subscribers. In what direction and to what extent will future developments carry the service plans? What is ahead? Who can say? Much depends upon the extent to which Uncle Sam inserts himself into the health benefits field. How great that penetration will be depends to no small degree upon how the service plans throughout the country meet the challenge of providing acceptable coverage for federal employees. The Congress has taken the advocates of voluntary health insurance at their word. It has provided the employees of the federal government with a program so voluntary that each employee may not only select the type of plan he prefers, but may also elect not to participate in any manner if he so desires.

Truly may it be said that Blue Shield has responded to the requirements of modern health care. How well this venture succeeds depends inherently upon the cooperation and support of the medical profession.

FLORIDA MEDICAL ASSOCIATION ANNUAL MEETING, APRIL 8-11, JACKSONVILLE.

Vistaril® helps bring tranquility

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When she drinks to relieve her tensions, VISTARIL can help restore perspective. By maintaining tranquility, VISTARIL helps patients to accept counsel more readily, and encourages abstinence from drinking.

VISTARIL has shown a wide margin of safety, even in large doses, over prolonged periods. Clinical studies have shown that VISTARIL produces no significant lowering of blood pressure, pulse, or respiration in chronic drinkers.

Available as: *Capsules*—25, 50, and 100 mg. *Parenteral Solution (as the HCl)*—25 mg. per cc., 10 cc. vials and 2 cc. Steraject® Cartridges; 50 mg. per cc., 2 cc. ampules. Professional literature available on request from the Medical Department, Pfizer Laboratories. Brooklyn 6, New York.

Science for the world's well-being™ Pfizer

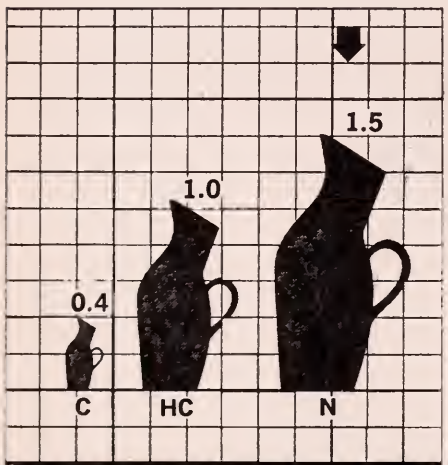
more closely approaches the ideal diuretic

Naturētin

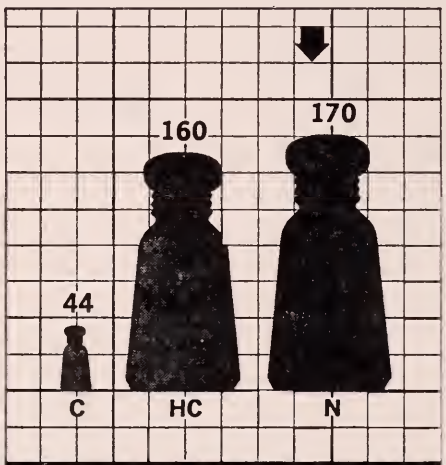
Squibb Benzydroflumethiazide

"When compared to other members of this heterocyclic group of compounds, this drug [NATURETIN] shows a significantly increased natriuresis and decreased loss of potassium and bicarbonate. In this respect it more closely approaches a natural or 'ideal diuretic.' It is effective upon continuous administration and causes no significant serum biochemical changes. It is effective in a wide variety of edematous and hypertensive states and represents a significant advance in diuretic therapy." *Ford, R.V.: Pharmacological observations on a more potent benzothiadiazine diuretic; accepted for publication by the American Heart Journal.*

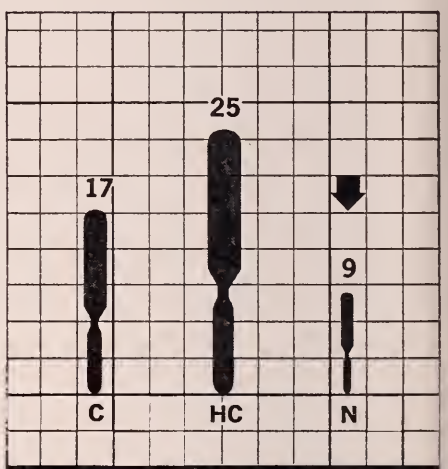
Comparison of electrolyte excretion pattern for the 24 hours following typical doses of chlorothiazide, hydrochlorothiazide, and Naturetin[1]



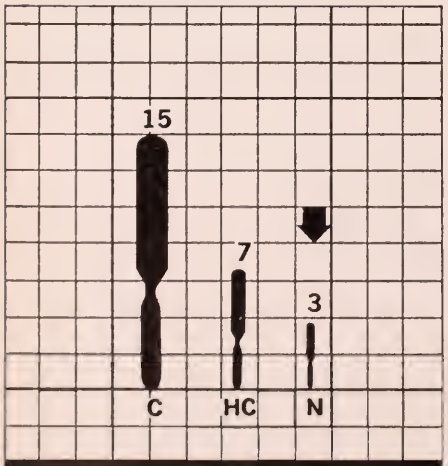
Urinary Volume (liters)
significantly increased
with Naturetin



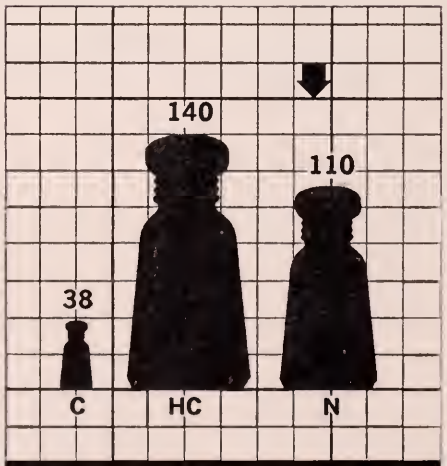
Natriuresis (mEq./24 hr.)
sodium excretion significantly
increased with Naturetin



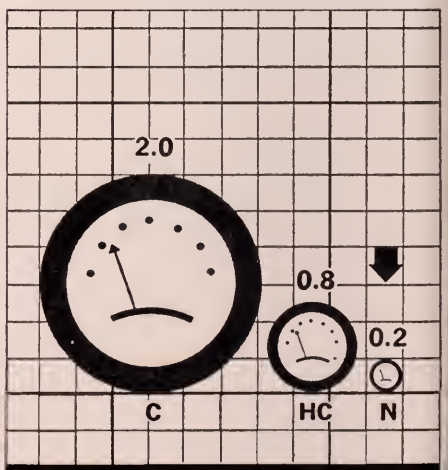
Potassium Excretion
(mEq./24 hr.)
least with Naturetin



Bicarbonate Excretion
(mEq./24 hr.)
least with Naturetin



Chloride Excretion
(mEq./24 hr.)
marked increases



Urinary pH
least increase with Naturetin

Typical Doses: Chlorothiazide—1,000 mg.; Hydrochlorothiazide—50 mg.; Naturetin (Benzydroflumethiazide)—5 mg.

1. Adapted from: Ford, R. V., Squibb Clin. Res. Notes 2:1 (Dec.) 1959

A single 5 mg. tablet once a day provides all these advantages[2]

- prolonged action — in excess of 18 hours
- convenient once-a-day dosage
- low daily dosage — more economical for the patient
- no significant alteration in normal electrolyte excretion pattern
- repetitively effective as a diuretic and antihypertensive
- greater potency mg. for mg.—more than 100 times as potent as chlorothiazide
- potency maintained with continued administration
- low toxicity — few side effects — low salt diets not necessary
- comparative studies with chlorothiazide, hydrochlorothiazide, and Naturetin disclose that smallest doses of Naturetin produce greater weight loss per day
- in hypertension, Naturetin, alone or in combination with other anti-hypertensives, produces significant decreases in mean blood pressure and other favorable clinical effects
- purpura and agranulocytosis not observed
- allergic reactions rarely observed

[2]Reports (1959) to the Squibb Institute for Medical Research.

laturētin —*Indications:* in control of edema when diuresis is required, in congestive heart failure, ı the premenstrual syndrome, nephrosis and nephritis, cirrhosis with ascites, edema induced by drugs certain steroids); in the management of hypertension, used alone, combined with Raudixin (Squibb auwolfia Serpentina Whole Root), or with other antihypertensive drugs, such as ganglionic blocking agents.

'ontraindications: none, except in complete renal shutdown.

'recautions: when Naturetin is added to an antihypertensive regimen including hydralazine, eratrum, and/or ganglionic blocking agents, immediate reduction must be made in the dosage for all reparations; the dosage for ganglionic blocking agents must be decreased by 50% to avoid a precipitous rop in blood pressure. This also applies if these hypotensive drugs are added to an established Naturetin egimen . . . in hypochloremic alkalosis with or without hypokalemia . . . in cirrhotic patients or those on igitalis therapy when reductions in serum potassium are noted . . . in diabetic patients or those redisposed to diabetes . . . when increased uric acid concentrations are noted . . . when signs— g or abdominal cramps, pruritus, paresthesia, rash—suggestive of hypersensitivity, are noted.

laturētin —*Dosage: in edema,* average dose, 5 mg., once daily, preferably in the ıorning; to initiate therapy, up to 20 mg., once daily or in divided doses; for aintenance, 2.5 to 5.0 mg., daily in a single dose. *In hypertension:* suggested ıitial dose, 5 to 20 mg. daily; for maintenance, 2.5 to 15 mg. daily, depending n the individual response of the patient. When Naturetin is added to an anti-ypertensive regimen with other agents, lower maintenance doses of each rug should be used.

aturētin —*Supplied:* tablets of 2.5 mg. and 5 mg. (scored).

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Pyridoxine HCl (B_6)	5 mg.
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STATE NEWS ITEMS

The ninety-third annual meeting of the American Otological Society is being held in the Deauville Hotel at Miami Beach March 13-14. The program will be devoted to scientific papers and reports of research on otological subjects. Dr. J. Brown Farrior of Tampa is scheduled to participate in the informal discussions. Physicians concerned with hearing function are cordially invited to attend the scientific meetings.

Dr. Hugh A. Carithers of Jacksonville attended a meeting of the Selection Committee for Pediatric Residency Fellowships sponsored by Wyeth Laboratories in Philadelphia January 8-10.

Dr. Edward R. Annis of Miami was the featured speaker at an assembly of the seventh and eighth grades of Fowler High School at Hialeah early in December. Dr. Annis discussed the use of alcohol and tobacco.

Dr. Francis W. Glenn of Coral Gables presented a paper on the subject of childhood fractures at the 20th annual meeting of the American Fracture Association held early in November at New Orleans.

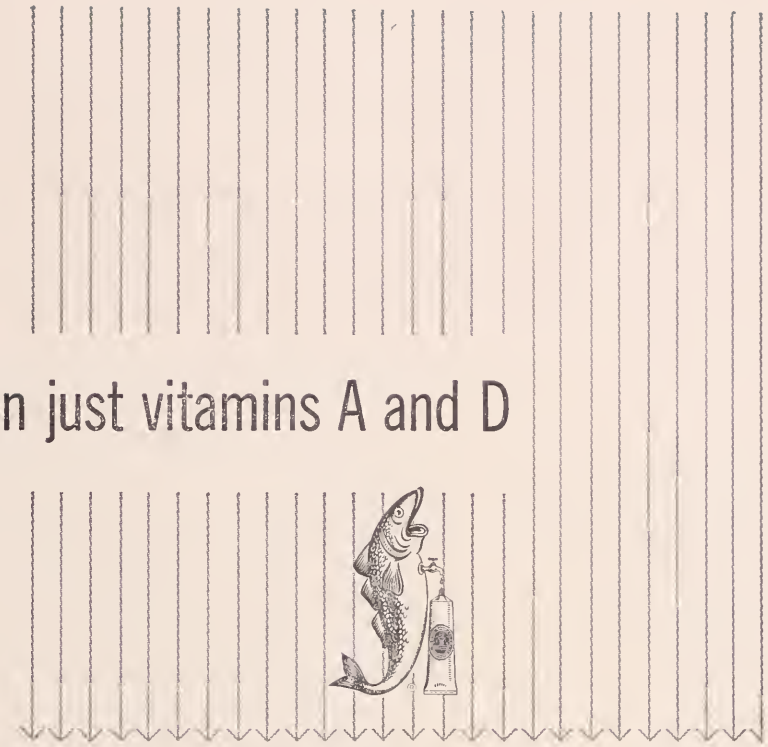
Dr. Francis T. Holland of Tallahassee has been re-elected chairman of the Florida Committee on Rural Health.

Dr. Clifford C. Snyder of Miami has been elected assistant secretary of the American Society of Plastic and Reconstructive Surgery.

Dr. Lester R. Dragstedt of Gainesville, Professor of Surgery at the College of Medicine, University of Florida, has been awarded the 1959 Honor Award of the Mississippi Valley Medical Society for distinguished contribution to the field of clinical medicine.

Drs. George F. Schmitt Jr. and Clifford C. Snyder of Miami, and Drs. Lance Lester, William R. Ploss and Herman K. Moore of Key West attended the Annual Congress of Government Medical Officers held late in November in Jamaica, B.W.I. Dr. Schmitt presented an address on the treatment of hypertension, and Dr. Snyder gave a lecture on plastic procedures in pediatric

more than just vitamins A and D



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Administration and Dosage: For topical anesthesia, Xylocaine HCl 4% may be applied as a spray or with cotton applicators or packs, and by instillation into a cavity. The suggested volume ranges, for adults, from one to five cc. (40-200 mg.). For children, debilitated and aged patients, dosages should be proportionately reduced. Prior to removal of foreign bodies from the eye, examination of corneal lacerations, cauterization of corneal ulcers, and other surgical and diagnostic procedures, 2 to 3 drops of Xylocaine HCl 4% will usually produce adequate anesthesia. *How Supplied:* For Transtracheal and Retrobulbar Injection and Topical Application—Sterile aqueous solution dispensed in 5 cc. color-break ampules, packed 10 ampules to a carton. For Topical Use Only—Aqueous solution in 50 cc. screw cap bottles, individually cartoned.

*U.S. Patent No. 2,441,498 Made in U.S.A

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surgery and also an illustrated lecture on his recent visit to Russia.

The new $213,080 National Guard Armory at St. Petersburg has been named for Dr. N. Worth Gable of St. Petersburg. A general order by command of Governor LeRoy Collins stated that designation was made as "a mark of honor and in recognition of the distinguished military service" rendered the State and National Guard by Dr. Gable, who retired as brigadier general in 1958.

Dr. Louis M. Orr of Orlando, President of the American Medical Association, and Dr. Samuel P. Martin of Gainesville, Chairman of the Department of Medicine, College of Medicine, University of Florida, will participate in the program of the 56th Annual Congress on Medical Education and Licensure being held in Chicago, February 6-9. Dr. Orr will deliver the Fifth Annual Walter L. Bierring Lecture on Monday evening, February 8, and Dr. Martin will discuss "Clinical Education as a Continuum" Sunday afternoon, February 7, as a part of the overall discussed of the topic "The Role of Patient Care in Education Beyond the Medical School."

A Seminar in Obstetrics and Gynecology is being held at St. Francis Hospital, Miami Beach, February 4-6, each day from 9:00 a.m. until noon under the professorship of Dr. Herbert E. Schmitz, Professor of Obstetrics and Gynecology at the Stritch School of Medicine of Loyola University, Chicago. Topics which will be discussed include "Benign and Malignant Lesions of the Vulva;" "Pre and Invasive Carcinoma of the Cervix;" "Endometrial Carcinoma;" "Indications for Hysterectomy;" "Diagnosis and Treatment of Diseases of the Endometrium," and "Treatment of Carcinoma of the Cervix Complicating Pregnancy."

Dr. Louis M. Orr of Orlando, President of the American Medical Association, was principal speaker at the Chamber of Commerce Forum in Portland, Ore., held early in December. The title of Dr. Orr's address was "Million Dollar Malarkey!"

Dr. Harriet Gillette of Gainesville, Chairman, Department of Physical Medicine at the College of Medicine, University of Florida, has been elect-

(Continued on page 1017)

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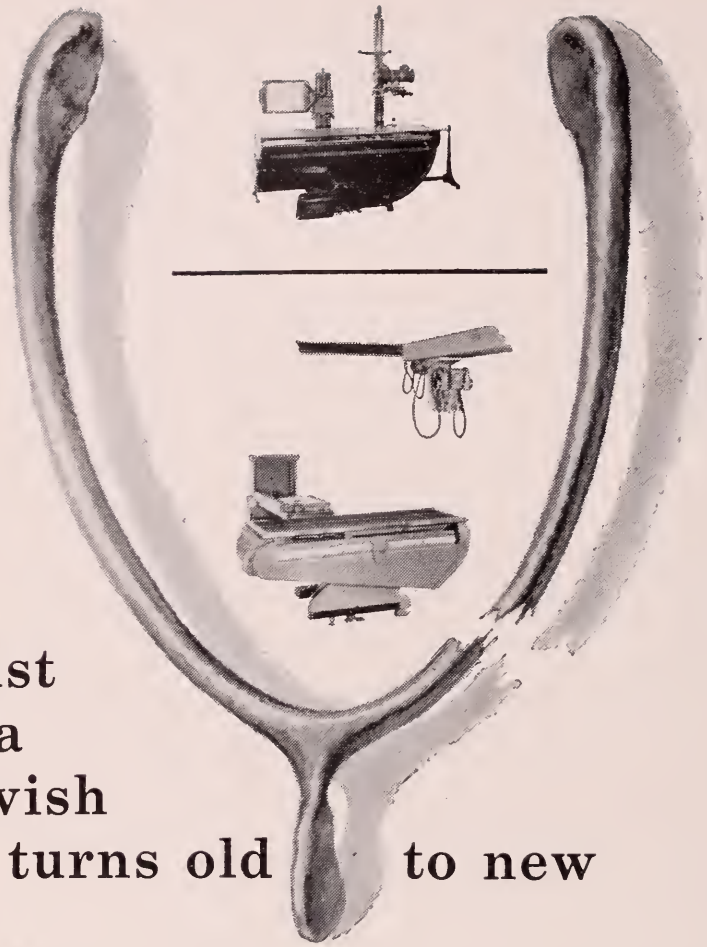

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trauma
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muscle spasm
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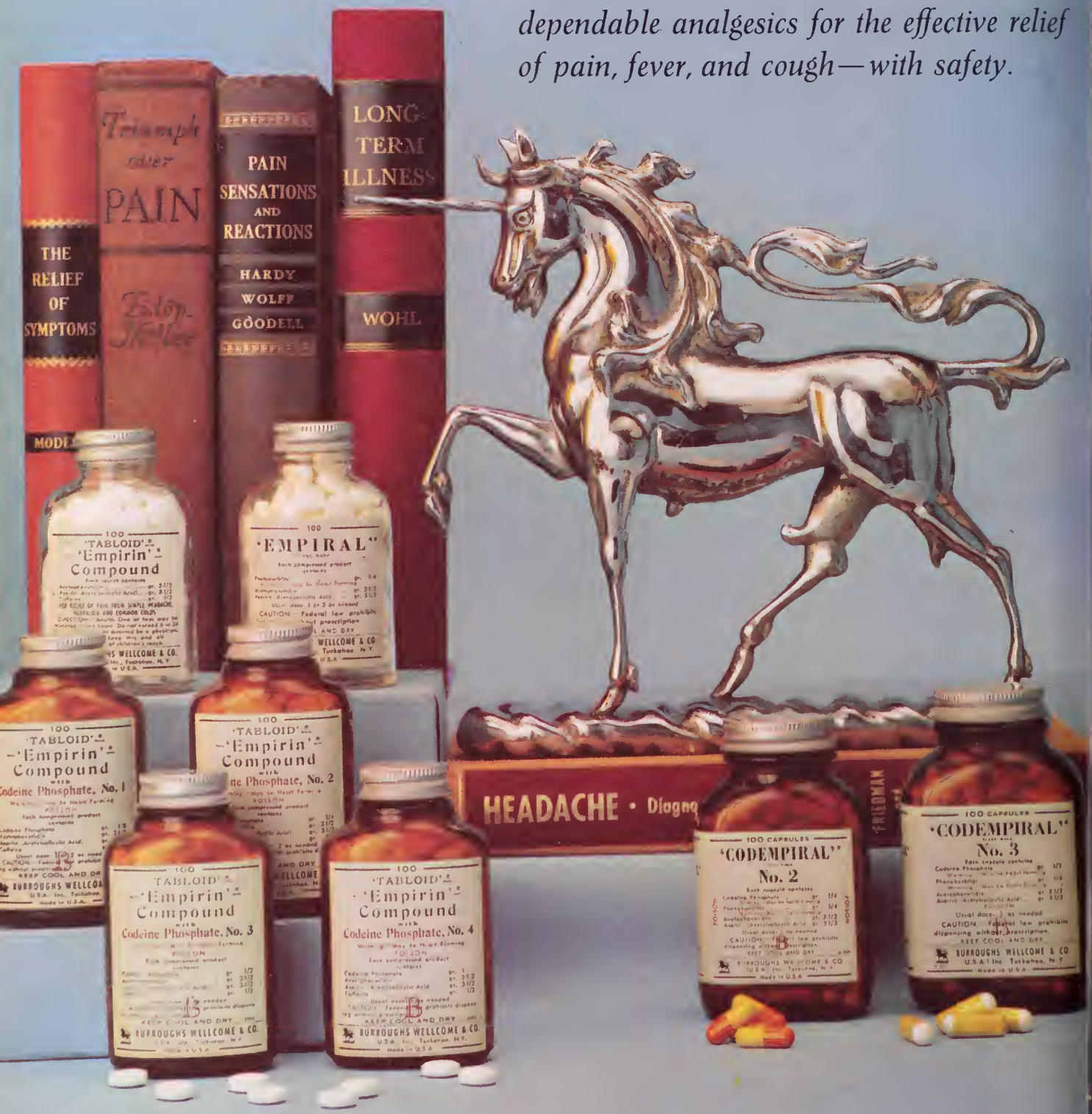

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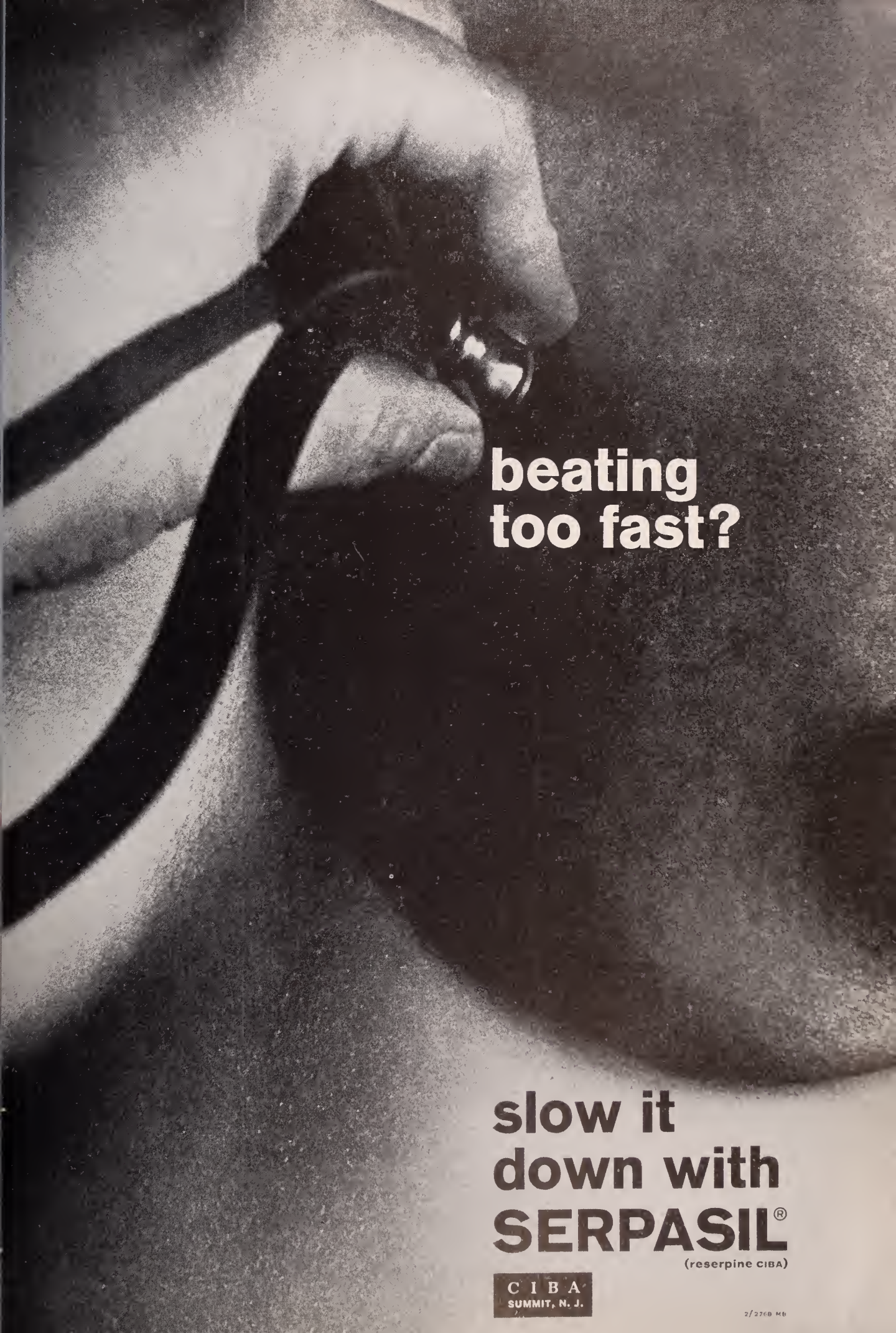
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of u.r.i. ... and relieve the
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Pneumonitis, otitis, tonsillitis, adenitis, sinusitis or bronchitis develops as a serious bacterial complication in about one in eight cases of acute upper respiratory infection.[1] To protect and relieve the "cold" patient...ACHROCIDIN.

Usual dosage: 2 tablets or teaspoonfuls q.i.d. (equiv. 1 Gm. tetracycline). Each TABLET contains: ACHROMYCIN® Tetracycline (125 mg.); phenacetin (120 mg.); caffeine (30 mg.); salicylamide (150 mg.); chlorothen citrate (25 mg.). Also as SYRUP (lemon-lime flavored), caffeine-free.

1. Based on estimate by Van Volkenburgh, V. A., and Frost, W. H.: Am. J. Hygiene 71:122 (Jan.) 1933

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(Continued from page 1011)

ed a member of the executive committee of the American Academy for Cerebral Palsy.

Dr. Nelson Zivitz of Miami Beach served as chairman of the Committee on Local Arrangements for the 16th annual meeting of the American Academy of Allergy held at Hollywood January 11-13. Assisting Dr. Zivitz were Drs. George Gittleson, Morton L. Hammond, James H. Putman and Harold Rand, all from Miami.

A grant of $256,986 has been received by the College of Medicine of the University of Florida, Gainesville, for research in infectious diseases and allergies from the National Institute of Allergy and Infectious Diseases. The grant will be administered by Dr. Emanuel Suter, Professor of Microbiology.

Dr. Anthony D. Migliore of Arcadia addressed the Rotarians of that city on January 5. He discussed the medical and surgical work at the G. Pierce Wood Memorial Hospital at Arcadia.

The annual meeting of the American Laryngological, Rhinological and Otological Society is being held at Miami Beach March 15-17.

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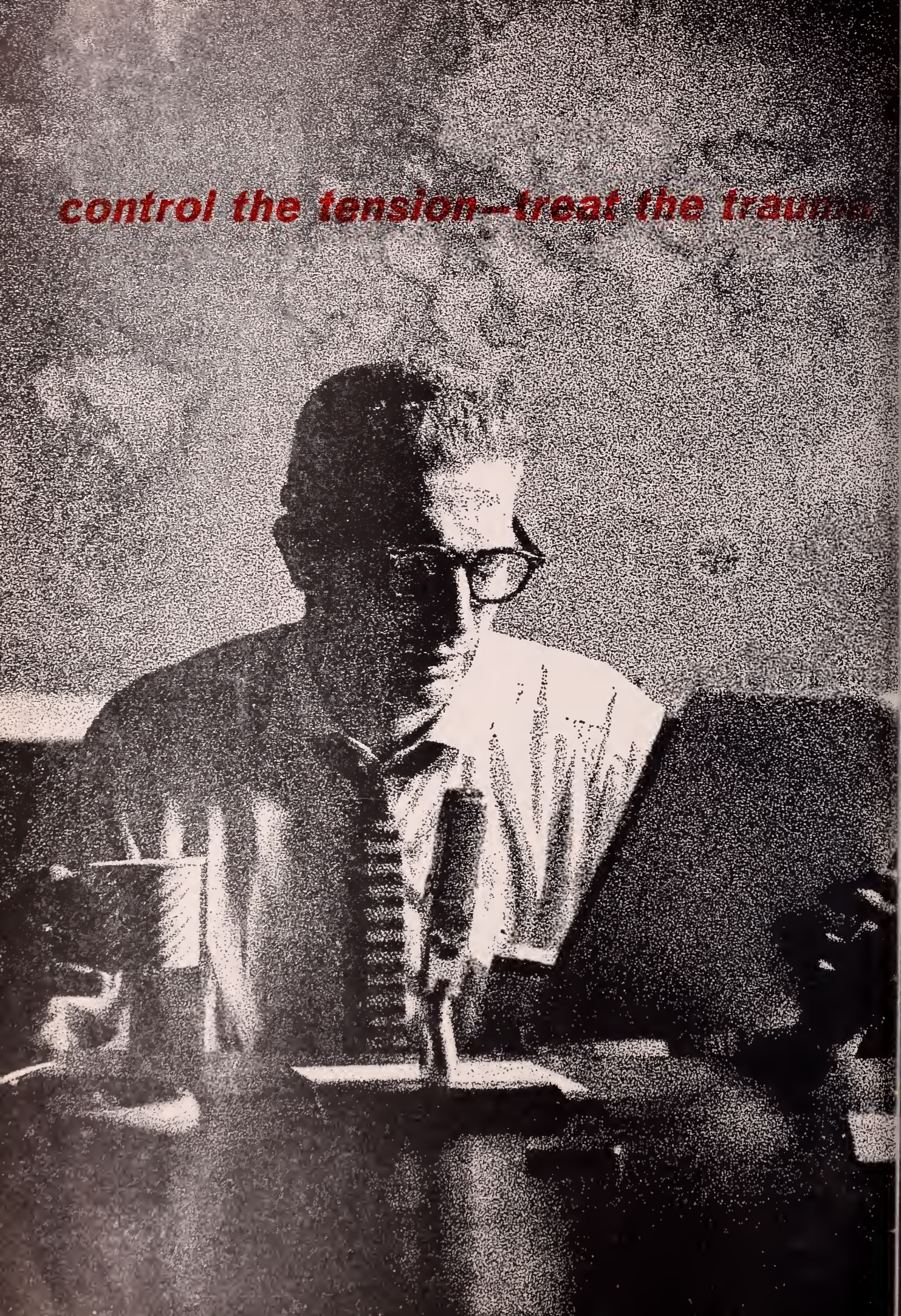
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Administration and Dosage: **PATHIBAMATE-400**—1 tablet three times a day at mealtime and 2 tablets at bedtime.

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Adjust to patient response.

Contraindications: glaucoma; pyloric obstruction, and obstruction of the urinary bladder neck.

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COMPONENT SOCIETY NOTES

Alachua

Dr. Eugene H. Cummings of Gainesville has been installed as president of the Alachua County Medical Society. Dr. Raymond J. Fitzpatrick of Gainesville has been elected president-elect. Serving this year with Drs. Cummings and Fitzpatrick will be Drs. Edward R. Woodward as vice president, Richard E. Perry as secretary and William C. Evans Jr. as treasurer.

Columbia

Dr. Harry S. Howell has been re-elected as president of the Columbia County Medical Society. Other officers re-elected at the Society's annual meeting in December included Dr. Louis G. Landrum as vice president and Dr. Thomas H. Bates as secretary-treasurer. All are from Lake City.

Escambia

Dr. William J. Overman of Warrington has begun serving as president of the Escambia County Medical Society following installation ceremonies at the Society's annual meeting. Dr. Pascal G. Batson Jr., president-elect, Dr. Henry M. Yonge, vice president, and Dr. Howard E. Herring Jr., secretary-treasurer, are the other new officers who will be serving during 1960. All are from Pensacola.

Highlands

Dr. Hubert W. Coleman of Avon Park has been elected president of the Highlands County Medical Society. Dr. Carl J. Larsen of Avon Park has been elected vice president, and Dr. Samuel A. King of Avon Park secretary-treasurer.

Indian River

Dr. Charles F. Rattray Jr. has been elected president of the Indian River County Medical Society for the new year. Dr. Phil D. Morgan. who served last year as secretary-treasurer, has been chosen as vice president and Dr. Walter W. McCorkle as secretary-treasurer. All are from Vero Beach.

Jackson-Calhoun

Dr. William R. Wandeck of Marianna has been elected president of the Jackson-Calhoun County Medical Society. The new vice president is Dr. Terry Bird of Blountstown. Dr. Francis

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Preferably, antibiotic therapy should be based on pretreatment culture of the offending pathogen, but in bacterial pneumonia the problem may well be too pressing to permit the required delay of 24 to 48 hours. A differential diagnosis among bacterial pneumonias, based on such clinical grounds as speed of onset, sepsis and pain may guide the choice of antibiotic for initiation of therapy.

Should clinical judgment dictate that antibiotic therapy be started immediately, at the same time a sputum sample or a subglottic swab can be sent to the laboratory for culture and sensitivity studies. If the response to the first antimicrobial agent proves unsatisfactory, a reasonable basis for changing therapy will then be at hand.

Choosing the Antibiotic

Since therapy must be started at once for bacterial pneumonia, it is advisable to choose a broad-spectrum antibiotic that quickly produces high levels of active agent (e.g., tetracycline phosphate complex, TETREX). Such an antibiotic probably has the best chance of controlling the pathogen, whether it be gram-negative or gram-positive. And if the laboratory report shows that the invading organism is much less sensitive to tetracycline than to other agents, the patient can then be changed to an appropriate antibiotic. If the difference in sensitivity is slight, then the possibility of side effects, sensitization, and toxicity should be evaluated before changing therapy to another antibiotic.

The greatest number of bacterial pneumonias are caused by pneumococci, which respond very well to penicillin, tetracycline, and chloramphenicol. Also, these antibiotics are usually effective against the other gram-positive coccal pneumonias. But penicillin is ineffective against the viral pneumonias and the gram-negative *Hemophilus influenzae* and *Klebsiella pneumoniae*. Although *K. pneumoniae* causes only about 1 to 2 per cent of pneumonia cases on the average,[1] these are apt to be acute and fulminating (Friedländer's pneumonia), with a high mortality rate if not effectively treated. Since pneumococcal pneumonia may be difficult to distinguish clinically from Friedländer's, except by gram-stained sputum smear, it may be wiser to start treatment with an agent also effective against Klebsiella.

Penicillin, however, in addition to having a limited spectrum, also causes many minor and some serious sensitivity reactions. In a recent survey[2] it was found that penicillin produced severe skin reaction. But most important was the observation that anaphylactic shock, with a fatality rate of about 9 per cent, was the most frequent serious reaction. Such severe reactions are almost always associated with parenteral administration.

Tetracycline is also clinically effective in primary atypical pneumonia.[3]

The tetracyclines (e.g., TETREX) have the advantage of a broad range of antimicrobial activity and low toxicity. And in addition, the physician does not have to trouble himself or his patients with repeated blood studies when he prescribes TETREX. Minor reactions such as gastric upsets or mild skin rashes occur occasionally. The most serious side effects are staphylococcal and monilial overgrowth, but these are rare and can be adequately controlled.

No one would deny that appropriate antibiotic therapy has greatly reduced morbidity and saved many lives of patients with bacterial pneumonia. Nevertheless, general supportive measures in the care of patients remain important even today. Especially in the desperately ill patient, antibiotics are not considered as substitutes for the individual evaluation, clinical observation and judgment of the physician.

Some Micro-organisms Susceptible[a] *to Tetracycline* (TETREX)[b]

Streptococcus; Staphylococcus; Pneumococcus; Gonococcus; Meningococcus; *C. diphtheriae; B. anthracis; E. coli;* Proteus; *A. aerogenes; Ps. aeruginosa; K. pneumoniae;* Shigella; Brucella; *P. tularensis; H. influenzae; T. pallidum;* Rickettsiae; Viruses of psittacosis and ornithosis, lymphogranuloma inguinale, primary atypical pneumonia; *E. histolytica; D. granulomatosis.*

a Some strains are not susceptible.

b Table adapted from Goodman, L. S., and Gilman, A.: The Pharmaceutical Basis of Therapeutics, 2nd edition, New York, The Macmillan Co., 1956, pp. 1322-1323.

References: 1. Wood, W. E., Jr.: In: A Textbook of Medicine. Edited by Cecil, R. L., and Loeb, R. F., 9th edition, Philadelphia, W. B. Saunders Co., 1955, p. 145. 2. Welch, H.; Lewis, C. H.; Weinstein, H. I., and Boeckman, B. B.: Severe reactions to antibiotics. A nationwide survey. Antibiotic Med. & Clin. Ther. 4:800 (Dec.) 1957. 3. Keefer, C. S.: The choice of an anti-infective agent. In: Drugs of Choice, 1958-1959. Edited by Walter Modell, St. Louis, The C. V. Mosby Co., 1958, p. 135.

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M. Watson of Marianna has been re-elected secretary-treasurer.

Lake

Dr. Arthur P. Buchanan of Leesburg has been elected president of the Lake County Medical Society, and Dr. Lawton F. Douglass of Umatilla, who served last year as vice president, has been chosen president-elect. Dr. Thomas D. Weaver of Clermont has been re-elected secretary-treasurer.

Lee-Hendry

Dr. George D. Hopkins II began serving as president of the Lee-Hendry County Medical Society in December. Elected at the annual meeting to serve with Dr. Hopkins were Dr. Wilson A. Rumberger as vice president and Dr. Leland K. Glenn as secretary-treasurer. All are from Fort Myers.

Leon-Gadsden-Liberty-Wakulla-Jefferson

Dr. Edson J. Andrews has been elected president of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society after serving last year as vice president. Dr. Nelson H. Kraeft, formerly secretary-treasurer, has been chosen as vice president, and Dr. David J. McCulloch as secretary-treasurer. All are from Tallahassee.

Madison

Dr. A. Franklin Harrison has been elected president of the Madison County Medical Society, and Dr. Thomas G. Bouland has been chosen as secretary. Both are from Madison.

Monroe

Dr. Walter R. McCook has been elected president of the Monroe County Medical Society after having served during 1959 as vice president. Dr. Allen Shepard has been chosen as vice president, and Dr. Joseph L. G. Lester Jr. as secretary-treasurer. All are from Key West.

Orange

Dr. W. Dean Steward of Orlando has been installed as president of the Orange County Medical Society. Chosen as president-elect at the Society's recent annual meeting was Dr. Robert L. Stephens also of Orlando. Dr. Albert H. Gleason of Winter Garden has been elected vice president. Dr. Joseph G. Matthews has been chosen as treasurer, and Dr. Robert W. Curry has been

(Continued on page 1027)

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Kuge, T.: Submitted for publication.

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Wein, A. B.: The Use of Carisoprodol in Orthopedic Surgery and Rehabilitation. Proceedings of the Symposium on The Pharmacology and Clinical Usefulness of Carisoprodol. Wayne State University Press, Detroit, 1959, p. 156.

In a double-blind study, Soma was reported to be "clinically effective to a highly significant degree." (92 patients.)
Cooper, C. D., and Epstein, J. H.: The Clinical Evaluation of Carisoprodol by a double-blind technique. Ibid. p. 97.

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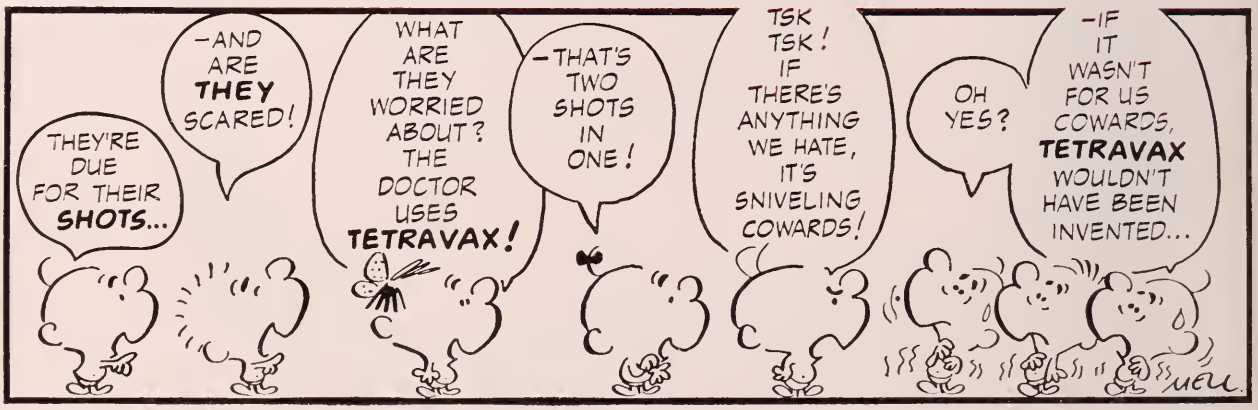

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(Continued from page 1022)

re-elected secretary. Drs. Matthews and Curry are also from Orlando.

The Orange County Medical Society's television program "With These Hands" televised from station WLOF-TV in Orlando has been awarded the Merit Award Certificate by the Florida Public Relations Association.

Palm Beach

Dr. Willard F. Ande has begun serving as president of the Palm Beach County Medical Society following installation ceremonies at the Society's recent annual meeting. Dr. William H. Proctor, who served as treasurer last year, has been chosen president-elect to take office at the end of 1960. Other officers include Dr. Horace D. Atkinson as vice president, Dr. Herman Baxt as secretary and Dr. James F. Cooney as treasurer. Dr. Baxt was re-elected. All are from West Palm Beach.

Polk

Dr. Charles Larsen Jr. has been installed as president of the Polk County Medical Association after having served as president-elect last year. Chosen president-elect at the recent annual meeting was Dr. John E. Daughtrey. Drs. Larsen and Daughtrey are from Lakeland. Dr. Arthur J. Moseley Jr. of Winter Haven has been elected vice president, and Dr. Clarence L. Anderson of Lakeland has been re-elected secretary-treasurer.

St. Lucie-Okeechobee-Martin

Dr. Joseph H. Batsche has been elected president of the St. Lucie-Okeechobee-Martin County Medical Society, and Dr. Maltby F. Watkins has been re-elected secretary-treasurer. Both are from Fort Pierce.

Seminole

Dr. Edwin Epstein has been chosen as president of the Seminole County Medical Society. Other officers elected to serve with Dr. Epstein during 1960 include Dr. Clyde F. B. Smith as vice president and Dr. Robert J. Smith as secretary-treasurer. All are from Sanford.

Suwannee-Hamilton-Lafayette

Dr. Frederick T. Mickler Jr. of Jasper has been elected president of the Suwannee-Hamilton-Lafayette County Medical Society, and Dr. Irby H. Black of Live Oak has been chosen as secretary-treasurer.

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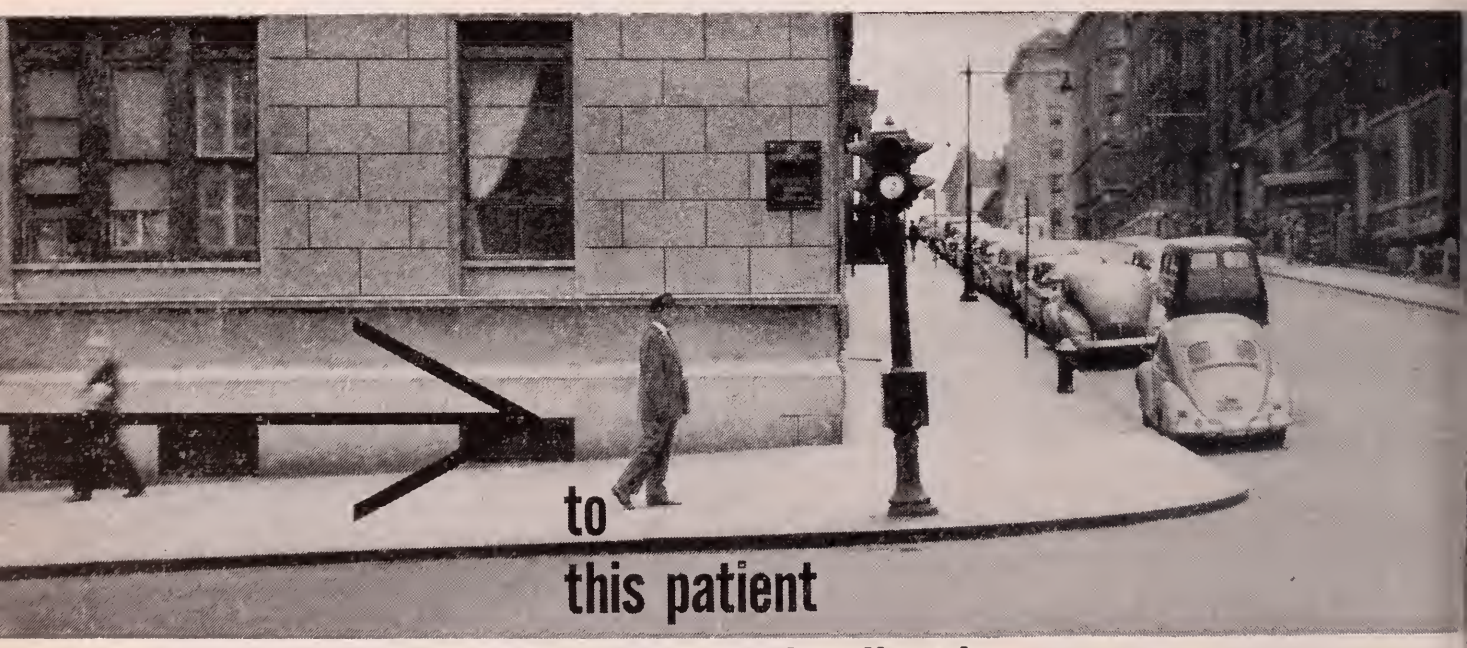

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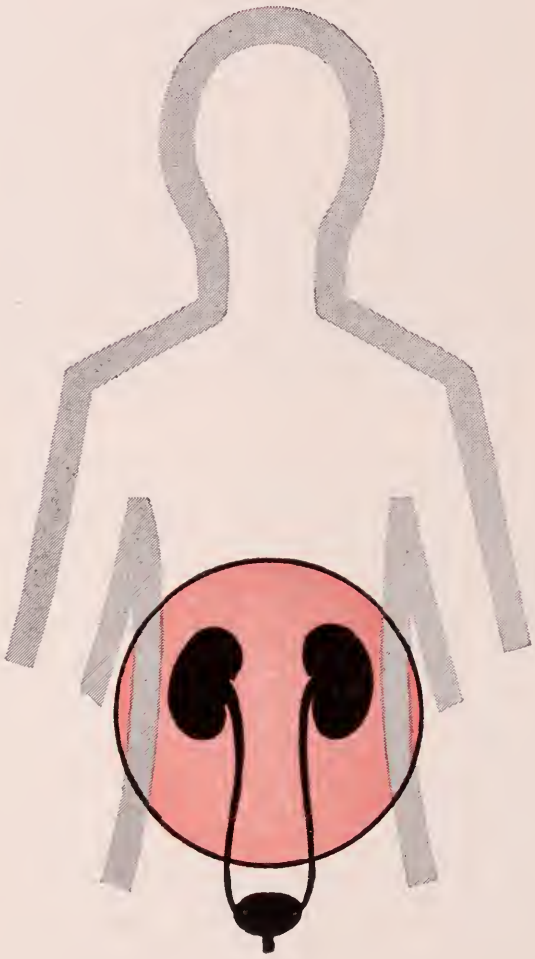

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1. Ford, R. A., and Blanchard, K.: Journal-Lancet 78:185, 1958.

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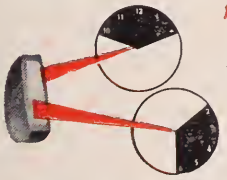

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Dosage (to be administered every 3 or 4 hours): *Adults* — 1 or 2 tsp.; *Children 6 to 12* — 1 tsp.; *Children 1 to 6* — ½ tsp.; *Children under 1* — ¼ tsp.

1. Fabricant, N. D.: E.E.N.T. Monthly *37*:460 (July) 1958.
2. Lhotka, F. M.: Illinois M. J.: *112*:259 (Dec.) 1957.
3. Farmer, D. F.: Clin. Med. *5*:1183 (Sept.) 1958.

the leading oral nasal decongestant...

Triaminic®

timed-release tablets and juvelets
also non-alcoholic, fruit-flavored syrup

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NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Abarbanel, Milton G., West Hollywood
Batchelder, Theodore L., Jacksonville
Cassidy, Robert E., Miami Shores
Fernandez, Mario, Miami
Gladson, Noel R., Jacksonville
Gurganious, Edgar W. Jr., Jacksonville
Haswell, Forrest M., Jacksonville
Holtzman, Saul C., St. Petersburg
Ireland, Treadwell L., Pompano Beach
Jarrell, Walter G., Jacksonville
Koenig, Alfred D., St. Petersburg
Orlick, Arnold H., St. Petersburg
Ott, Franklin B., Pompano Beach
Paar, James A., St. Petersburg
Pavlik, Charles E., West Palm Beach
Sheahan, Robert C., Deerfield Beach
Todd, Ethan O. Jr., Jacksonville
Updegraff, Ambrose G., St. Petersburg
Ware, Newton C., Jacksonville
Wilkinson, Albert H. Jr., Jacksonville

BIRTHS, MARRIAGES AND DEATHS

Birth

Dr. and Mrs. Robert A. Shashy of Jacksonville announce the birth of a daughter, Peggy Ann, on November 23.

Marriages

Dr. Edwin Davis of Daytona Beach and Miss Sandra Diane Wood of Jacksonville were married on November 26 at St. Augustine.

Dr. Walton B. Wall Jr. of Orlando and Miss Gee Gee Gahr of Winter Park were married on November 29 at Winter Park.

Deaths — Member

Hahn, Theodore F., DeLand.....August 20, 1959

Deaths — Other Doctors

Draper, Arthur Derby, Tampa.....September 26, 1959

Gardiner, Leo Lloyd, Coral Gables.....August 18, 1959

McClellan, Henry J., St. Petersburg.....August 10, 1959

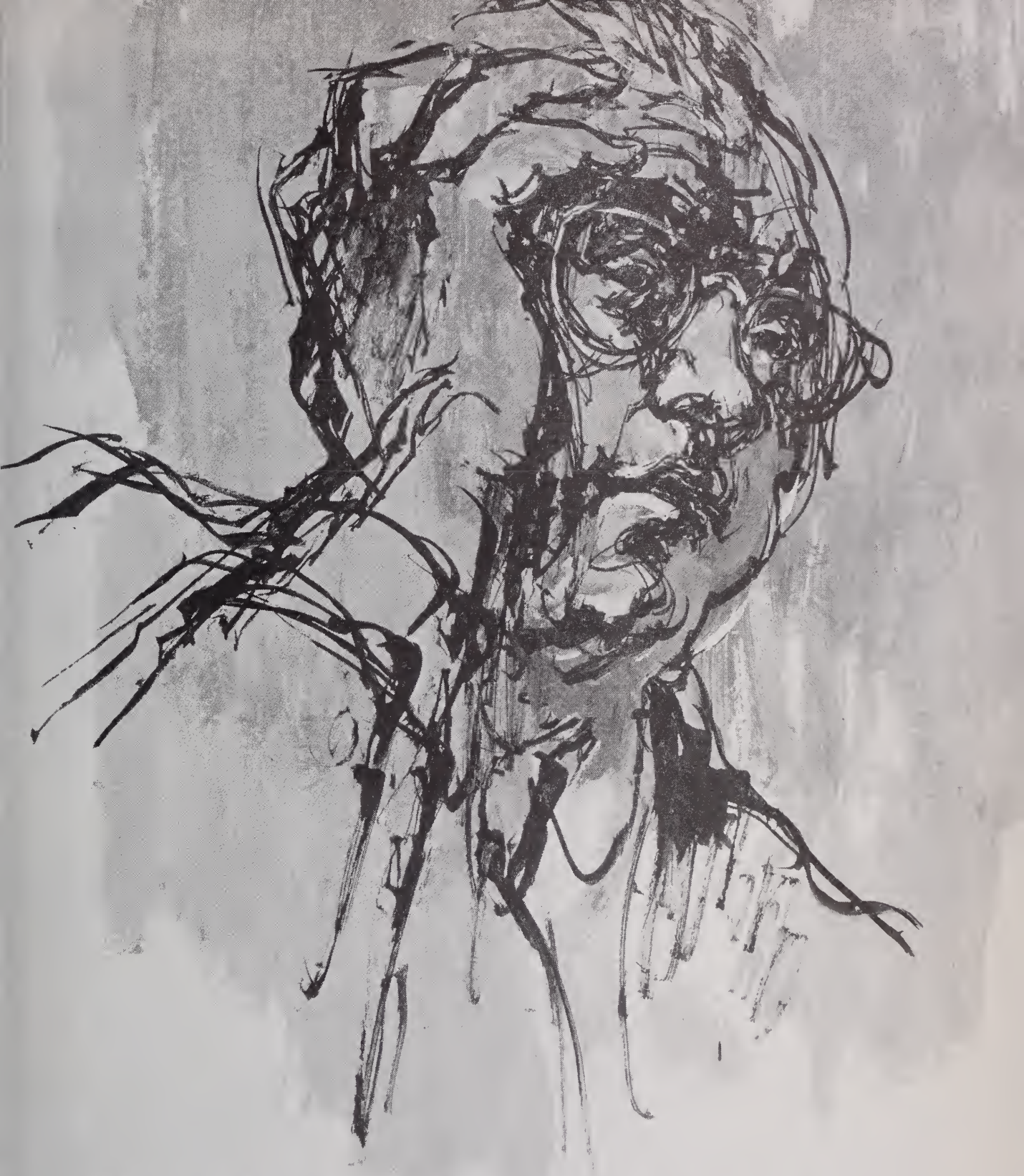
Stephens, Hiram Aubrey,
Ponce de Leon.....September 15, 1959

Wentworth, Daniel W., St. Petersburg.....July 29, 1959

Williams, Tom A., London, England.....May 27, 1959

Wilson, James C., Holly Hill.....August 23, 1959

Zasly, Louis, Delray Beach.....November 2, 1959



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SUPPLIED: Tablets #2 (standard-strength, scored), each containing 0.2 mg. Serpasil and 50 mg. Apresoline hydrochloride; Tablets #1 (half-strength, scored), each containing 0.1 mg. Serpasil and 25 mg. Apresoline hydrochloride.

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properties

greater inhibitory action...lower intake pe dose...DECLOMYCIN produces equivalent or greater clinical activity with less antibiotic because of two basic factors: (1) increased potency, and (2) longer retention.

broad-spectrum control in depth. Higher activity level enhances range of previous antibiotics. Some problem pathogens have been found more responsive. Strains of Pseudomonas, Proteus and *A. aerogenes* have proved sensitive to DECLOMYCIN

sustained activity level. DECLOMYCIN maintains a more constant level of activity. Infection is quickly resolved.

24-48 hours extra activity...protectio against relapse. Antimicrobial control is maintained after stopping dosage. Most other antibiotics dissipate rapidly on withdrawal.

REFERENCES:

1-11. Papers read at Seventh Symposium on Antibiotics Washington, D. C., November 4-6, 1959.
12. Phillips, F. M.: DECLOMYCIN—Seventh Interim Report Department of Clinical Investigation, Lederle Laboratories Pearl River, N. Y., December 4, 1959.

CAPSULES, 150 mg., bottles of 16 and 100.
Dosage: average adult, 1 capsule four times daily.
PEDIATRIC DROPS, 60 mg./cc. in bottle of 10 cc. with calibrated dropper.
ORAL SUSPENSION, 75 mg./5 cc. tsp. in 2 oz. bottle.

new broad-spectrum
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performance

genitourinary infection. Roberts, M. S.; Seneca, H., and Lattimer, J. K.,[1] New York, N. Y.—Ninety-one percent of the Gram-positive and 27 per cent of the Gram-negative, among 66 organisms cultured from genitourinary infection, responded to DECLOMYCIN. Serum antibiotic activity was found three times greater than with tetracycline.

toleration. Boger, W. P., and Gavin, J. J.,[2] Norristown, Pennsylvania—Side effects with DECLOMYCIN were minimal. When dosage was 0.5 to 1 Gm. daily in divided doses, only two of 82 patients exhibited nausea.

activity level sustentation. Kunin, C. M.; Dornbush, R. C., and Finland, M.,[3] Boston, Massachusetts—Of the four tetracycline analogues, DECLOMYCIN Demethylchlortetracycline showed the longest sustained activity levels in the blood.

gonococcal infection. Marmell, M., and Prigot, A.,[4] New York, N. Y.—Of 63 cases of gonorrhea, 61 promptly responded after short courses of DECLOMYCIN. Therapeutic effect was found equal to that of intramuscular penicillin.

bronchopulmonary infection. Perry, D. M.; Hall, G. A., and Kirby, W. M. M.,[5] Seattle, Washington—Of 30 cases of acute bacterial pneumonia, all were afebrile following two to 10 days of treatment with DECLOMYCIN. Results were good in 21. . . . All of six patients with acute bronchitis responded promptly.

pediatric infection. Fujii, R.; Ichihashi, H.; Minamitani, M.; Konno, M., and Ishibashi, T.,[6] Tokyo, Japan—In 309 pediatric patients with various infections, DECLOMYCIN was effective in 75 per cent.

urogenital infection. Vineyard, J. P.; Hogan, J., and Sanford, J. P.,[7] Dallas, Texas—Clinical response in pyelonephritis correlated well with results of *in vitro* sensitivity tests, which showed some strains of *A. aerogenes*, Proteus and Pseudomonas more susceptible to DECLOMYCIN Demethylchlortetracycline than to its analogues.

pneumonia. Duke, C. J.; Katz, S., and Donohoe, R. F.,[8] Washington, D. C.—Results were satisfactory in all but two of 32 cases of acute bacterial pneumonia, of which only 11 were uncomplicated. No side effects were observed.

brucellosis. Chávez Max G.,[9] Mexico, D. F., Mexico—All of nine patients with *Br. melitensis* infection were afebrile after five days on DECLOMYCIN. Blood cultures were negative in all cases on the 20th day. Side effects were limited to slight temperature increases which abated in four days.

pustular dermatosis. Blau, S., and Kanof, N. B.,[10] New York, N. Y.—Results with DECLOMYCIN were excellent in both of two cases of impetigo, one of two cases of folliculitis, six of nine cases of furunculosis, all of three cases of acne rosacea and 26 of 45 cases of acne vulgaris. Overall, results were excellent or good in 85 per cent.

antibacterial spectrum. Finland, M.; Hirsch, H. A., and Kunin, C. M.,[11] Boston, Massachusetts—DECLOMYCIN Demethylchlortetracycline was found the most effective of the tetracycline analogues against two-thirds of 680 normally sensitive strains of 15 separate species.

the over-all picture. Combined results reported by 210 clinical investigators[12]—DECLOMYCIN produced a favorable response (cured or improved) in 87 per cent of 1,904 patients. Two-thirds of the patients received one capsule every six hours. Treatment was continued for as long as 180 days, but was between three and eight days in most. Side effects were seen in 9.9 per cent, but necessitated discontinuance of treatment in only 1.8 per cent.

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DOSAGE: Adults—2 tablets three times daily.
Children from 6 to 12 years—
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Bottles of 20 and 100 tablets.

Neo-Synephrine (brand of phenylephrine) and Thenfadil (brand of thenyldiamine), trademarks reg. U. S. Pat. Off.

Shouldn't **KANTREX**® Injection* be kept in reserve for treating staph or gram-negative infections until other antibiotics have been tried first?

a No. Naturally, KANTREX Injection should not be used in mild or self-limited infections, but as Yow states, "it should not be withheld in moderately severe or severe infections."

Q *What properties of* KANTREX *led Yow to draw this conclusion?*

Next page, please

* Kanamycin sulfate injection (Bristol)

Q *What properties of* KANTREX *led Yow to draw this conclusion?*

a The following[2]: (1) KANTREX Injection is bactericidal, not merely bacteriostatic; (2) it is absorbed rapidly after intramuscular injection; (3) it has proved successful in many types of staph and gram-negative infections resistant to other antibiotics; and (4) it is well tolerated when used judiciously.

Q *But if I use* KANTREX *Injection, won't that help make bacteria resistant to it?*

a Numerous investigators have reported that micro-organisms do not readily develop resistance to KANTREX in a clinical setting; and emergence of resistance to KANTREX has not been a practical problem.[2,4,5,6,7,8]

Q *How does the* in vitro *activity of* KANTREX *against staph compare with that of other antibiotics?*

a Griffith and Ostrander[9] tested 794 strains of staphylococci and found that 95.2% were sensitive to KANTREX. By contrast, only 15.5% of the same organisms were sensitive to penicillin, 33.5% to tetracycline, 52.4% to erythromycin, and 71.7% to chloramphenicol.

Q *What about the sensitivity of other pathogens to* KANTREX*?*

a Leming[10] recently summarized the *in vitro* activity of KANTREX against 4493 strains of various organisms isolated from hospital patients over a 7-month period. He reported that the following percentages of these clinical isolates were sensitive to KANTREX: *Proteus mirabilis*, 98%; *Proteus morganii*, 94%; *Proteus rettgeri*, 89%; *Proteus vulgaris*, 87%; *Porocolobactrum intermedium*, 96%; *Coli-aerogenes* group, 93%; *Streptococcus viridans*, 78%; *Salmonella* and *Shigella*, 92%.

Q *What do these figures mean clinically?*

a A great deal. As Yow stated in recent reviews of KANTREX Injection, it "appears to be one of the most effective anti-staphylococcal antibiotics available today."[1,2] KANTREX Injection is also effective in the treatment of infections caused by "most strains of *E. coli*, *Proteus sp.*, the *Klebsiella pneumoniae-Aerobacter aerogenes* group, and many strains of *Pseudomonas aeruginosa* resistant to other antibiotics."[2] In another report, KANTREX Injection was placed at the head of the list of drugs "with the most chance of success" against *A. aerogenes* urinary tract infections.[11]

Q *Have these findings about* KANTREX *therapy been substantiated by other investigators?*

a Yes, indeed. Finegold,[12] who reviewed the clinical findings of 64 investigators, reported that infections which "usually responded" to KANTREX included: staph infections (including staph enteritis), *E. coli* infections (including *E. coli* gastroenteritis), atypical acid-fast bacillus infections, *Aerobacter-Klebsiella* infections, paracolon infections, *Alcaligenes* infections, *Shigella* dysentery, *Salmonella* enteritis, anthrax, amebiasis, and *E. histolytica* carrier state. Among the infections that "sometimes responded" were listed: pneumococcal infections, group A *beta*-hemolytic streptococcic infections, *Proteus* infections, gonorrhea, and paratyphoid fever.

Q *That's an impressive list. What didn't respond?*

a According to Finegold's tabulation, treatment failures were "usually" encountered in brucellosis, *Pseudomonas* infections, typhoid fever, mycotic infections and anaerobic infections.[12]

Q *How long do I have to give* KANTREX *Injection before I know whether it works or not?*

a Generally 2 or 3 days or less. Usually the effectiveness of KANTREX Injection can be determined in 24 to 36 hours. Rutenburg et al. reported that "the rapidity with which bacteria are killed by this agent is reflected by the promptness of the clinical response."[13]

MORE QUESTIONS on the clinical use of KANTREX®

Q *How long should I continue to administer* KANTREX?

a If definite clinical response does not occur within 5 days, KANTREX therapy should be stopped and the antibiotic sensitivity of the invading organism rechecked.

Q *What is the hazard of a patient developing hearing loss during* KANTREX *therapy?*

a In well hydrated patients with normal kidney function receiving KANTREX at the recommended dosage schedule, the hazard of ototoxic reactions is negligible. In patients with impaired kidney function, the risk of ototoxic reactions is sharply increased, and in such cases the dosage should be reduced. Finegold has stated: "Toxicity inherent in the drug can be avoided or minimized with careful management."[12]

Q *Why should renal impairment influence the dosage?*

a Because renal impairment delays the excretion of KANTREX Injection and causes an excessive accumulation in blood and tissues. Such excessive concentrations increase the risk of ototoxicity. Dosage recommendations emphasize that adequate serum levels can be achieved in such patients with a fraction of the dose suggested for patients with normal kidney function.

Q *Have you had any reports of blood dyscrasias?*

a None whatever.

Q *You mean, then, that a physician who uses* KANTREX *Injection judiciously should find it not only effective but also well tolerated?*

a Effective? Certainly, against almost all staph or "gram-negatives," even though they may be resistant to other antibiotics. Well tolerated? Yes, when given in recommended dosage. The physician can well agree with Yow, that while KANTREX Injection should not be used in mild or self-limited infections, "it should not be withheld in moderately severe or severe infections." That, indeed, is the time to give it – first!

KANTREX CAPSULES

for local gastrointestinal therapy... not for systemic infections

Q *If* KANTREX *is not absorbed from the G.I. tract, what are the capsules used for?*

a Preoperative bowel sterilization, and local treatment of intestinal infections due to kanamycin-sensitive organisms.

Q *What types of intestinal infections, for instance?*

a Acute and chronic shigellosis,[14] acute and chronic salmonellosis,[4,14,15,16] amebiasis,[17] bacillary dysentery,[18] infantile diarrhea,[10,18] gastroenteritis,[19] and staphylococcal enterocolitis.[2]

Q *For preoperative bowel sterilization, why should I switch from neomycin to* KANTREX *Capsules?*

a Because KANTREX has been rated superior to neomycin for this purpose.[20,21,22] Out of 30 intestinal antiseptics studied, KANTREX was designated "the only single agent classified as a preferred drug."[21] KANTREX "consistently eliminated all aerobic bacteria within 72 hours (and often within 24 to 36 hours) if a purgative was given with the first dose to expedite passage through the gastrointestinal tract."[12]

Q *Is that all the advantage* KANTREX *has over neomycin for preoperative bowel sterilization?*

a Not at all, there are several others. Diarrhea, nausea and vomiting have not been observed with KANTREX, though they occur frequently with neomycin; yeasts do not proliferate, in contrast to rapid growth with neomycin; and clostridia are well controlled with KANTREX, and not controlled with neomycin.[20,21,22]

KANTREX

INJECTION KANAMYCIN SULFATE INJECTION

INDICATIONS

Infections due to kanamycin-sensitive organisms, particularly those caused by gram-negative organisms, such as urinary tract infections, including those of the renal pelvis, surgical infections, respiratory tract infections, including septicemia and bacteremia, osteomyelitis and peritonitis, staphylococcal enteritis and gastrointestinal infections.

DOSAGE INTRAMUSCULAR ROUTE

Usual daily dose is 15 mg per kg of body weight, in 2 to 4 divided doses. (See detailed recommendations in insert accompanying each package.)

TOXICITY

When dosage recommendations are followed, the incidence of toxic reactions to KANTREX is low. In well hydrated patients with normal kidney function receiving a total dose of 7 Gm or less of KANTREX, the risk of severe ototoxic reactions is negligible.

In patients with impaired renal function or pre-renal azotemia, the daily dose of KANTREX should be reduced to avoid accumulation of the drug in serum and tissues, thus minimizing the possibility of ototoxicity. In such patients, if therapy is expected to last 5 days or more, audiograms should be obtained prior to and during treatment. KANTREX therapy should be stopped if tinnitus or objective hearing loss develops or if audiograms show significant loss of high frequency response.

OTHER ROUTES OF ADMINISTRATION

KANTREX should be used by intravenous infusion only when the intramuscular route is impracticable. KANTREX can also be employed for intraperitoneal use, aerosol treatment, and as an irrigating solution. See package insert for direction.

PRECAUTIONS

Use of antibiotics may occasionally result in overgrowth of non-sensitive organisms. If superinfection appears during therapy, appropriate measures should be taken.

SUPPLY

Available in rubber-capped vials as a ready-to-use sterile aqueous solution in two concentrations (stable at room temperature indefinitely):

KANTREX Injection, 0.5 Gm. kanamycin (as sulfate) in 2 ml. volume.
KANTREX Injection, 1.0 Gm. kanamycin (as sulfate) in 3 ml. volume.

CAPSULES (For local gastrointestinal therapy, not for systemic medication)

INDICATIONS AND DOSAGE

For preoperative bowel sterilization: 1.0 Gm (2 capsules) every hour for 4 hours, followed by 1.0 Gm (2 capsules) every 6 hours for a total of 72 hours.

For intestinal infections: Adults: 3.0 to 4.0 Gm (6 to 8 capsules) per day in divided doses for 5 to 7 days. Infants and children: 50 mg per kg per day in 4 to 6 divided doses for 5 to 7 days.

PRECAUTION

Preoperative use of KANTREX Capsules is contraindicated in the presence of intestinal obstruction. Although only negligible amounts of KANTREX are absorbed through intact intestinal mucosa, the possibility of increased absorption from ulcerated or denuded areas should be considered.

SUPPLY

KANTREX Capsules, 0.5 Gm kanamycin (as sulfate), bottles of 20 and 100.

REFERENCES

[illegible]

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WINE...

Rx Now widely prescribed for the chronic invalid, the convalescent, the debilitated oldster

Physicians treating the aged and the convalescent have for generations been aware of the restorative power of wine. However, it remained for recent research* to more clearly define its clinical physiological action.

Wine Increases Appetite—Goetzl and co-workers[1] observed a profound stimulating effect on olfactory acuity and appetite, even in anorexia.

Wine Aids Gastric Digestion—Ogden and Southard[2] reported a significant increase in gastric secretion following ingestion of moderate amounts of table wine.

Wine Helps in Cardiology—Prudent quantities of wine are helpful[3] in counteracting depression, anxiety and discomfort in sufferers from heart and coronary disorders.

Wine—"safest of all sedatives..."[4]—A little Port or Sherry at bedtime offers a valuable relaxant to the insomniac and may obviate the need for drug-sedative medication.

In brief, wine taken with discretion adds greatly to the pleasures of the table, to physical comfort and to mental serenity in the aged, as well as in the chronic sufferer and the convalescent.

Research information on wine is available on request. Write for your copy of *"Uses of Wine in Medical Practice." Wine Advisory Board, 717 Market Street, San Francisco 3, California.

1. Goetzl, F.R.: Permanente Found. M.Bull. *8*:72 (April) 1950.
2. Ogden, E., and Southard, F.D., Jr.: Fed. Proceedings *5*:77 (1946)
3. Brooks, H.: Med. J. & Rec. *127*:199 (1928)
4. Haggard, H.W., and Jellinek, E.M.: Alcohol Explored, New York, Doubleday, Doran, 1942.

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depresses appetite and elevates mood

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eases tensions of dieting
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BOOKS RECEIVED

Synopsis of Ophthalmology. By William H. Havener, B.A., M.D., M.S. (Ophth). Pp. 288. Illus. 189. Price $6.75. St. Louis, The C. V. Mosby Company, 1959.

Here is a book that covers its subject well and without an overindulgence in words. The author's adeptness in using descriptive photographs is extremely advantageous to the reader. The first chapter is devoted to eye examination in which not only the anatomy is described but the way to use it in diagnosing and treating existing defects, diseases and injury. The remaining chapters deal with medical and surgical emergencies as well as the chronic ophthalmological conditions. Each is carefully outlined, and the modern techniques of therapy are instituted. A great deal of emphasis is placed upon early diagnosis and correct therapy. The eye is used to make diagnoses of many systemic diseases, and the author dexteriously points these out in such a manner that even the medical student may understand them easily. In the last two chapters an appeal is made for consultation and referral of patients whose condition necessitates the attention of an ophthalmologist because such may eliminate complications and blindness that is preventable and unforgivable.

Clifford C. Snyder, M.D.

Synopsis of Ear, Nose, and Throat Diseases By Robert E. Ryan, B.S., M.D., M.S. (ALR), F.A.C.S. William C. Thornell, A.B., B.M., M.D., M.S. (ALR) F.A.C.S., and Hans von Leden, M.D., F.A.C.S., F.I.C.S Pp. 383. Illus. 59. Price $6.75. St. Louis, The C. V. Mos by Company, 1959.

The lake of learning is flooded with this type of text It is superfluous to the medical library which is alread overburdened with such material. The authors hav spent a great deal of valuable time and apparently i good thought, but their text is the average without excel ling in anything. It is too concise for the medical studen and intern, and offers little to the busy practitioner. Th book is divided into four parts concerning the ear, nos pharyx and larynx. The anatomy of these organs i described. Diagrams are utilized to illustrate the monot onous reading. The physiology of the anatomical part presents the usual pattern without offering anything ne and exciting. The portions dedicated to pathology del into the symptoms, and diseases are mentioned as suc under these various symptoms. Treatment is considere only with brevity. It is difficult to recommend such book because there are already so many dealing wit similar subjects that could fit into a library much easi and are not more expensive.

Clifford C. Snyder, M.D.

The Surgeon and the Child. By Willis J. Pott M.D. Pp. 255. Illus. 21. Price $7.50. Philadelphia, W. B Saunders Company, 1959.

The title of this carefully constructed book is an in vitation to peruse its contents. Upon reading the prefa one immediately realizes that the author has acquire his wisdom by disposition as well as by years. Once th reader has opened the text, he will find it difficult to clo until he has read the contents. It is easy reading becau the chapters fall in sequence from the cry of the co genitally malformed newborn to the older surgically child. The author in short chapters rewards the read by removing the confusion of diagnostic problems a outlines with clarity the treatment of them. With co ciseness, the preoperative care including the infant's ph sical examination, its fluid requirements and the anesthes is discussed. Emphasis is placed on the child's care i mediately after tying the last skin suture because it this phase of the surgical maneuver that presents t most complications. The remaining portions of the bo beautifully illustrate the common pediatric diseases th

Effective relief in rheumatic disorders

Sterazolidin® capsules
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with less risk of disturbing hormonal balance

In the treatment of the rheumatic disorders new Sterazolidin provides a method of limiting the gravest danger inherent in steroid therapy... hypercortisonism arising from excessive dosage.

Repeatedly it has been shown that the addition of low dosage of Butazolidin sharply reduces hormone requirement.[1-4] Sterazolidin is a combination of prednisone (1.25 mg.) and Butazolidin (50 mg.) which provides, in the majority of cases, consistent relief at a stable uniform maintenance dosage significantly below the level at which serious hormonal imbalance is likely to occur.

Sterazolidin® (prednisone-phenylbutazone Geigy). Each capsule contains prednisone 1.25 mg.; phenylbutazone 50 mg.; dried aluminum hydroxide gel 100 mg.; magnesium trisilicate 150 mg. and homatropine methylbromide 1.25 mg.

1. Kuzell, W. C., and others.: Arch. Int. Med. 92:646, 1953. 2. Wolfson, W. Q.: J. Michigan M. Soc. 54:323, 1955. 3. Strandberg, B.: Brit. J. Phys. Med. 19:9, 1956. 4. Platt, W. D., Jr., and Steinberg, I. H.: New England J. Med. 256:823 (May 2) 1957.

Geigy, Ardsley, New York

ultimately must be treated at the operating table. Many of the chapters include photographs and descriptive illustrations to assist the author in his writings. Dr. Potts should be commended for his work because the text can be enjoyed by surgeon and pediatrician, as well as teacher and student.

Clifford C. Snyder, M.D.

What Next, Dr. Peck? By Joseph H. Peck, M.D. Pp. 209. Price, $3.50. New York, Prentice Hall, Inc., 1959.

Thomas Carlyle said that history is too thickly studded with epidemics, massacres, earthquakes and other inconveniences. Everyone, he remarked, wants to know about the condition of his fellowmen, but the overwhelming mass of life is seldom available to historians. Coulton believed that the introduction of linen shirts marked the fourteenth century as advancing in personal hygiene and, by stimulating the manufacture of rag paper, giving aid to literature. He agreed, with Carlyle, that history needs the minute and the ordinary: in short, those things which make up most of our lives, scarcely any of which are of earth-shaking importance. They do make a sort of scaffolding upon which the catastrophes and beneficences of history may more properly be mounted for inspection.

So here is a book which demonstrates how the nooks and crannies of history might be filled with detail. It is a good book, though not a great one. Dr. Peck writes interestingly, and he has had wide experience. His journey through life (he is now 73) took him from Missouri to Utah, and much of the book is taken up with his adventures in that western state. I think doctors will like the book, and I recommend it as entertainment.

It is an interesting condition, and difficult to explain, in which this generation of doctors is enmeshed. Being modest, as is necessary, we must nonetheless admit that we have been exposed to more than the average amount of education. True, much of it was a sort of trade school exposure to techniques. On the other hand, all of us lived within the confines of a university for seven or eight, even 10 or 12 years. During that time, a certain amount of information other than medical must have rubbed off on us. The result? We go into practice, retire into the cocoon of our peculiar and necessary devotions, and proceed to allow the world to roll by.

We end up in our fifties or sixties more or less complete bores to ourselves, and enigmas to our fellow citizens. It has been a good many years since the word "scholar" has been heard in our midst. As a matter of fact, the word is seldom used, anywhere, today. Education has robbed its followers of the content of meaning of that term. They have, instead, concentrated so exclusively on how to teach that they come only, as an afterthought, to the matter of what they will teach. Lawyers are scholars, of a sort. Other professions, also, add their hint of knowledge beyond the commercial level.

The most highly educated members of the community, then, chance having their opinions formed by those who specialize in the use of language as a tool. This means those of the press, and journalists in general. But the use of words is a skill, and skill is not necessarily identified with understanding. A historian, for example, may be an excellent rhetorician, but pitifully inadequate in his observation of life as it is lived. A newspaperman may be a genius in the composition of a lead sentence or a headline, but a dud in humane cognition. Most doctors write as if they had Demosthenes' pebbles in their ink-stained fists. This does not diminish their worth as doctors, nor does it mean that all doctors could, or would care to write for other than medical consumption.

There must, however, be a few among us who could develop their grammar beyond the prosaic, and make

(Continued on page 1046)

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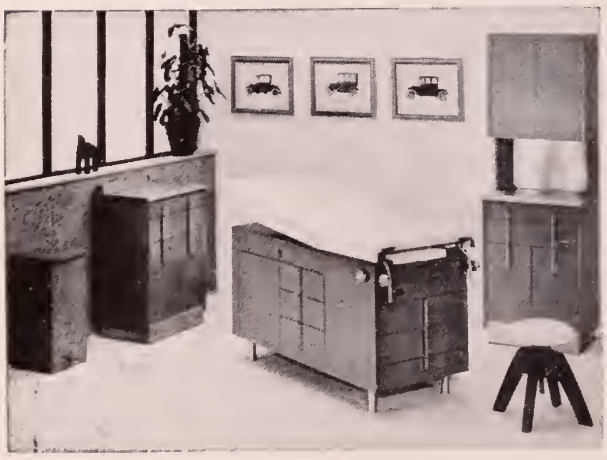

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1. Lippmann, O.: Arch. Ophth. **57**:339, March 1957.
2. Gordon, D.M.: Am. J. Ophth. **46**:740, November 1958.

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(Continued from page 1042)

their sentences less than a paragraph in length. There is nothing shameful about using language for purposes other than description and annotation, mixed with statistical minutiae. And the physician has not lived who does not remember experiences which are worth recording, for his colleagues and for all others. I think that it is not exaggerating to say that our present discontents, as a profession, stem from this virtuous and stubborn refusal to speak above a complex whisper.

Dr. Peck's book is one of a good many which have illuminated the practice of medicine as something besides the image which is now being developed, for us, by others. This image is of doctors wealthy, seldom available, unwilling to talk to their patients, and outrageously expensive. We know these things to be part falsehood, part exaggeration of our admitted imperfections. What better way to get the ear of that public which will, sooner or later, be asked to decide upon our future, than a simply written, unpretentious and interesting book about some facet of our experiences? This has been suggested, by others, one of them being the late Irwin Edman. He wished that doctors, as well as lawyers and statesmen, would write their views of Nature, or their conceptions of life. He believed that the best of them would be contributions to philosophy. Their wisdom might be on the worldly side, but it would be interesting to know "what our conquerors thought of the meaning of the world they had conquered." Anyone for literature?

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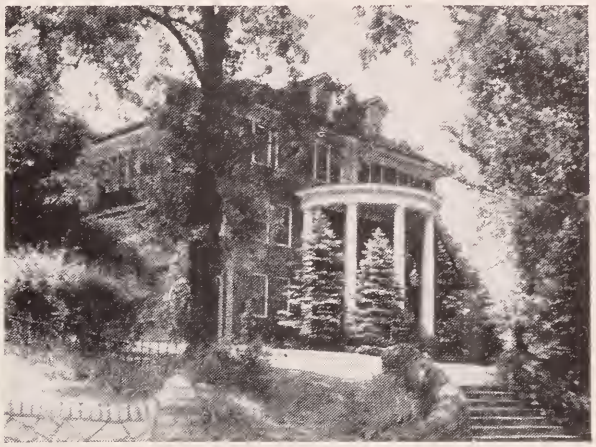

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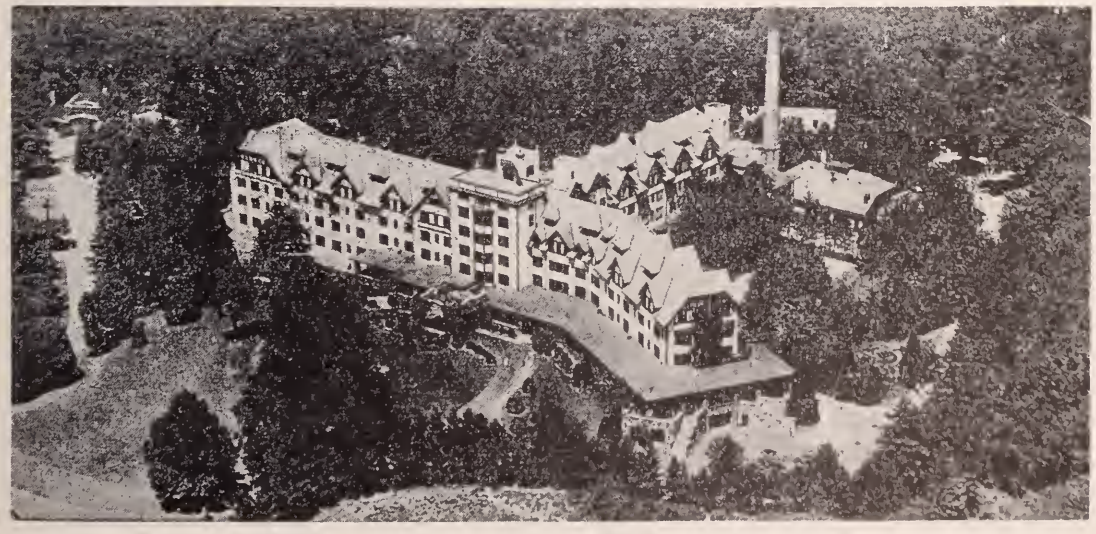

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Charlotte	Robert H. Shedd, Punta Gorda	Carl N. Reilly, Punta Gorda	2nd Tues.	5
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Columbia	Harry S. Howell, Lake City	Thomas H. Bates, Lake City	3rd Wed.	10
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DeSoto-Hardee-Glades	Harold S. Agnew, Arcadia	Elmer J. Schmierer, Arcadia	1st Tues.	13
Duval	Floyd K. Hurt, Jacksonville	Albert D. Rood, Jacksonville	1st Tues.	359
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Franklin-Gulf	Joseph P.Hendrix, Port St. Joe	Harold B. Canning, Wewahitchka	Last Wed.	6
Highlands	Hubert W. Coleman, Avon Park	Samuel A. King, Avon Park	1st Wed.	13
Hillsborough	Linus W. Hewit, Tampa	Frank A. Massari, Tampa	1st Tues.	239
Indian River	Charles F. Rattray Jr., Vero Beach	Walter W. McCorkle, Vero Beach	2nd Tues.	12
Jackson-Calhoun	William R. Wandeck, Marianna	Francis M. Watson, Marianna	Quarterly	17
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Nassau	David D. Bennett Jr., Callahan	Cecil B. Brewton, Fernandina Beach	1st Thurs.	6
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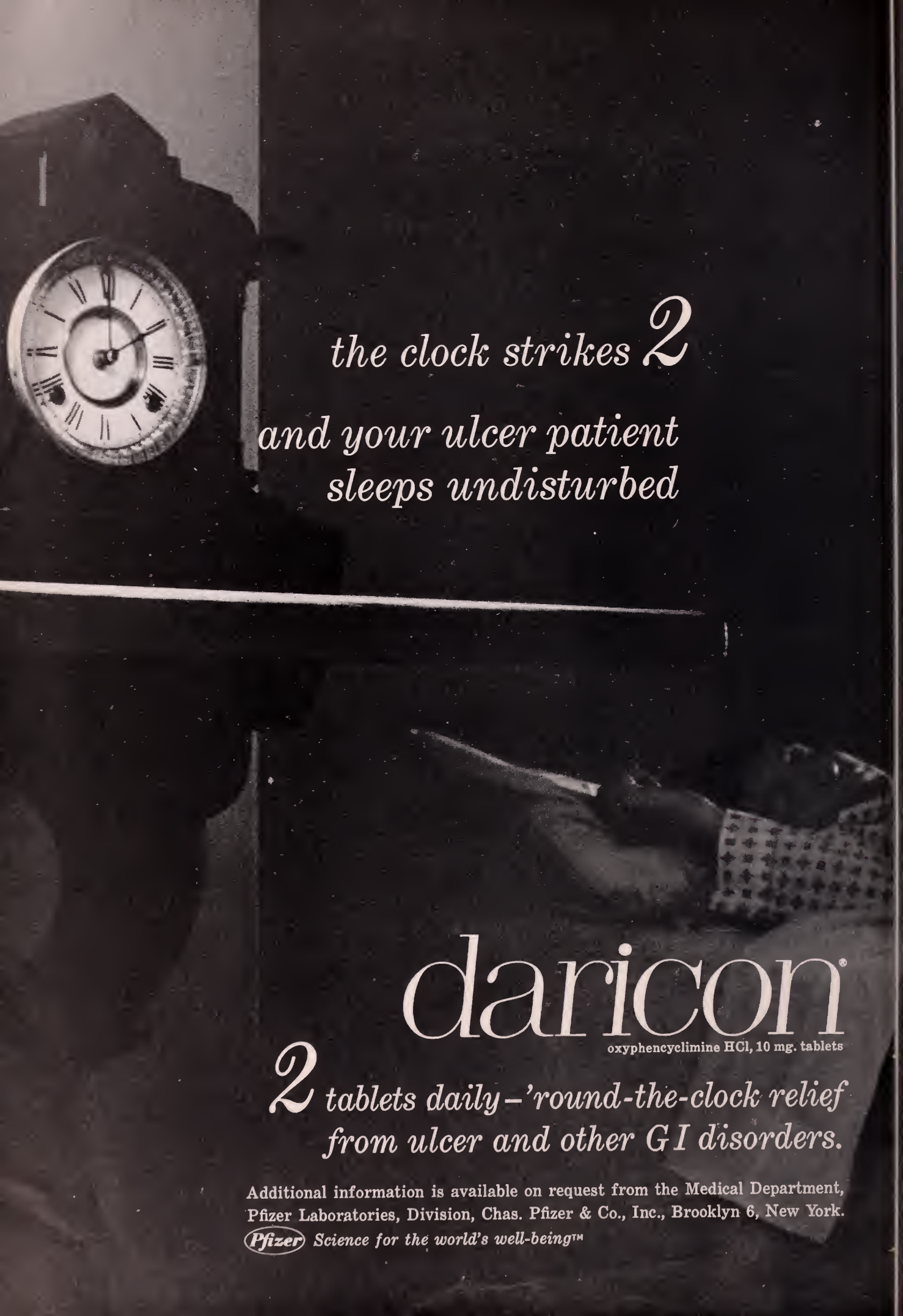
This Journal is not responsible for the opinions and statements of its contributors.
Owned and published by Florida Medical Association.

Published monthly at Jacksonville, Florida. Price $5.00 a year: single numbers, 50 cents. Address Journal of Florida Medical Association, P.O. Box 2411, 735 Riverside Ave., Jacksonville 3, Fla. Telephone EL 6-1571. Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918. Entered as second-class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida, October 23, 1924.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*Knudsen, E. T., and Rolinson, G. N.: Lancet 2:1105 (Dec. 19) 1959.

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1. Cook, J.E., Briggs, G.W., and Hindley, F.W.: Chronic Amebiasis and the Need for a Diagnostic Profile, Am. Pract. and Dig. of Treat. *6*:1821 (Dec., 1955).

2. Rinehart, R.E., and Marcus, H.: Incidence of Amebiasis in Healthy Individuals, Clinic Patients and Those with Rheumatoid Arthritis, Northwest Med., *54*:708 (July, 1955).

3. Webster, B.H.: Amebiasis, a Disease of Multiple Manifestations, Am. Pract. and Dig. of Treat. *9*:897 (June, 1958).

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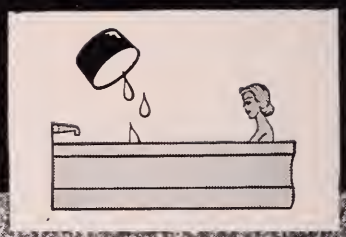

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1. Spoor, H. J.: N. Y. State J. Med. Oct. 15, 1958

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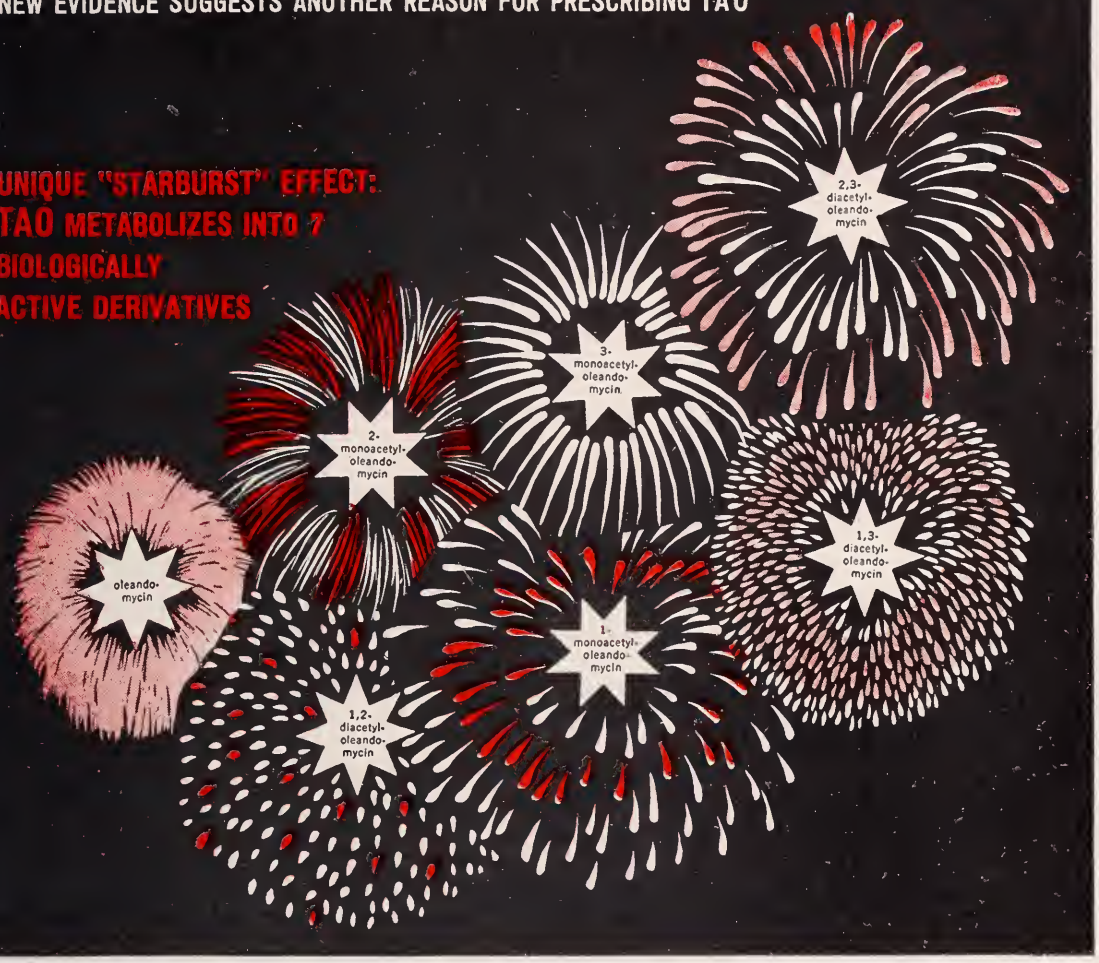

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1. English, A. R., and McBride, T. J.: Proc. Soc. Exper. Biol. & Med. 100:880 (Apr.) 1959. 2. Celmer, W. D.: Antibiotics Annual 1958-1959, New York, Medical Encyclopedia, Inc., 1959, p. 277. 3. English, A. R., and Fink, F. C.: Antibiotics & Chemother. 8:420 (Aug.) 1958.

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BIBLIOGRAPHY *(10 clinical studies, 714 patients)*:

1. Alexander, L. (35 patients): Chemotherapy of depression – Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrochloride. J.A.M.A. 166:1019, March 1, 1958. **2.** Bateman, J. C. and Carlton, H. M. (50 patients): Meprobamate and benactyzine hydrochloride (Deprol) as adjunctive therapy for patients with advanced cancer. Antibiotic Med. & Clin. Therapy 6:648, Nov. 1959. **3.** Bell, J. L., Tauber, H., Santy, A. and Pulito, F. (77 patients): Treatment of depressive states in office practice. Dis. Nerv. System 20:263, June 1959. **4.** Breitner, C. (31 patients): On mental depressions. Dis. Nerv. System 20:142, (Section Two), May 1959. **5.** McClure, C. W., Papas, P. N., Speare, G. S., Palmer, E., Slattery, J. J., Konefal, S. H., Henken, B. S., Wood, C. A. and Ceresia, G. B. (128 patients): Treatment of depression—New technics and therapy. Am. Pract. & Digest Treat. 10:1525, Sept. 1959. **6.** Pennington, V. M. (135 patients): Meprobamate-benactyzine (Deprol) in the treatment of chronic brain syndrome, schizophrenia and senility. J. Am. Geriatrics Soc. 7:656, Aug. 1959. **7.** Rickels, K. and Ewing, J. H. (35 patients): Deprol in depressive conditions. Dis. Nerv. System 20:364, (Section One), Aug. 1959. **8.** Ruchwarger, A. (87 patients): Use of Deprol (meprobamate combined with benactyzine hydrochloride) in the office treatment of depression. M. Ann. District of Columbia 28:438, Aug. 1959. **9.** Settel, E. (52 patients): Treatment of depression in the elderly with a meprobamate-benactyzine hydrochloride combination. Antibiotic Med. & Clin. Therapy. In press, 1959. **10.** Splitter, S. R. (84 patients): The care of the anxious and the depressed. Submitted for publication, 1959.

Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this may be gradually increased up to 3 tablets q.i.d.

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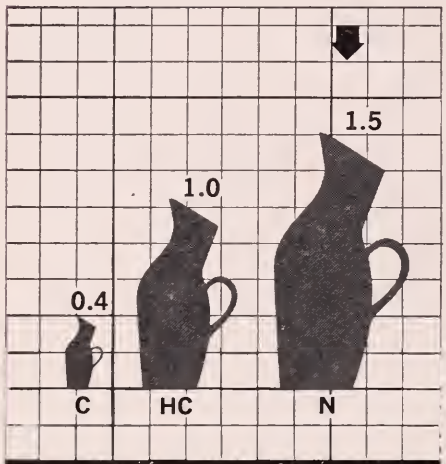
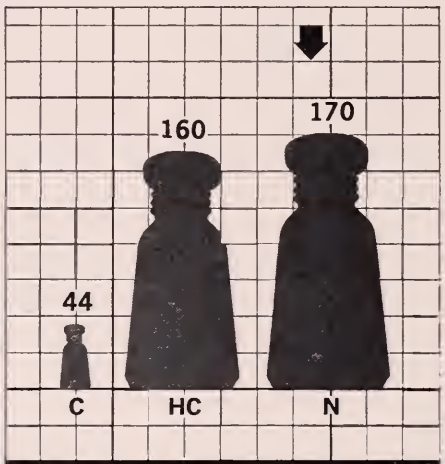
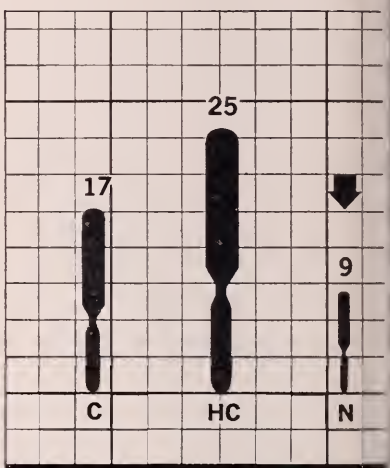
Comparison of electrolyte excretion pattern for the 24 hours followi typical doses of chlorothiazide, hydrochlorothiazide, and Naturet



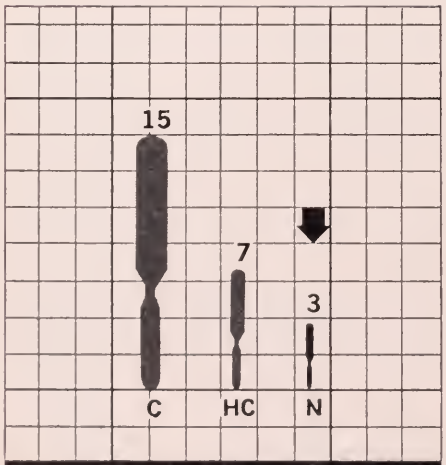
Urinary Volume (liters) significantly increased with Naturetin



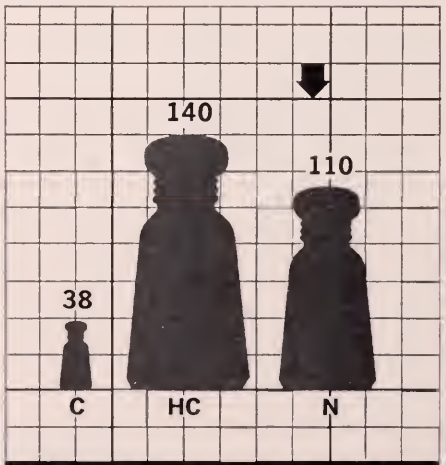
Natriuresis (mEq./24 hr.) sodium excretion significantly increased with Naturetin



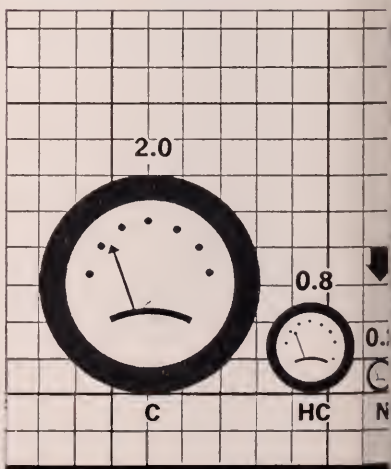
Potassium Excretion (mEq./24 hr.) least with Naturetin



Bicarbonate Excretion (mEq./24 hr.) least with Naturetin



Chloride Excretion (mEq./24 hr.) marked increases



Urinary pH least increase with Naturetin

Typical Doses: Chlorothiazide—1,000 mg.; Hydrochlorothiazide—50 mg.; Naturetin (Benzydroflumethiazide)—5 m

1. Adapted from: Ford, R. V., Squibb Clin. Res. Notes 2:1 (Dec.) 1959

A single 5 mg. tablet once a day provides all these advantages[2]

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- llergic reactions rarely observed

eports (1959) to the Squibb Institute for Medical Research.

ti ētin —*Indications:* in control of edema when diuresis is required, in congestive heart failure, premenstrual syndrome, nephrosis and nephritis, cirrhosis with ascites, edema induced by drugs in steroids); in the management of hypertension, used alone, combined with Raudixin (Squibb olfia Serpentina Whole Root), or with other antihypertensive drugs, such as ganglionic blocking agents.

ndications: none, except in complete renal shutdown.

utions: when Naturetin is added to an antihypertensive regimen including hydralazine, um, and/or ganglionic blocking agents, immediate reduction must be made in the dosage for all ations; the dosage for ganglionic blocking agents must be decreased by 50% to avoid a precipitous n blood pressure. This also applies if these hypotensive drugs are added to an established Naturetin n . . . in hypochloremic alkalosis with or without hypokalemia . . . in cirrhotic patients or those on is therapy when reductions in serum potassium are noted . . . in diabetic patients or those posed to diabetes . . . when increased uric acid concentrations are noted . . . when signs—abdominal cramps, pruritus, paresthesia, rash—suggestive of hypersensitivity, are noted.

ti ētin —*Dosage: in edema,* average dose, 5 mg., once daily, preferably in the ng; to initiate therapy, up to 20 mg., once daily or in divided doses; for enance, 2.5 to 5.0 mg., daily in a single dose. *In hypertension:* suggested dose, 5 to 20 mg. daily; for maintenance, 2.5 to 15 mg. daily, depending individual response of the patient. When Naturetin is added to an anti-ensive regimen with other agents, lower maintenance doses of each hould be used.

ti ētin —*Supplied:* tablets of 2.5 mg. and 5 mg. (scored).

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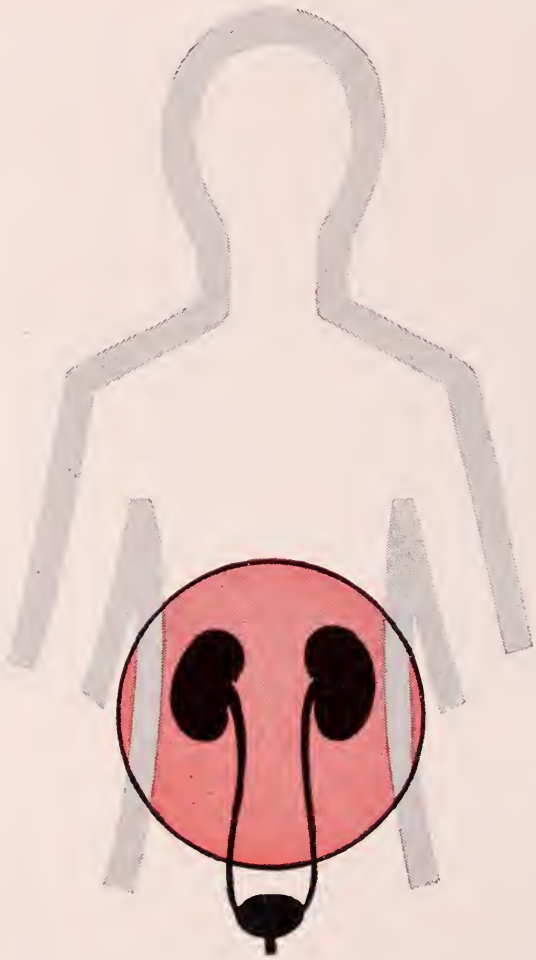

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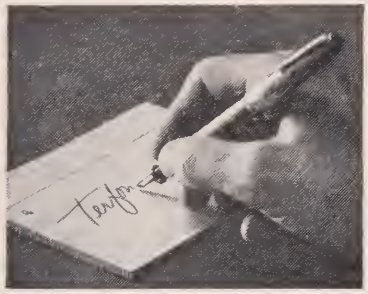

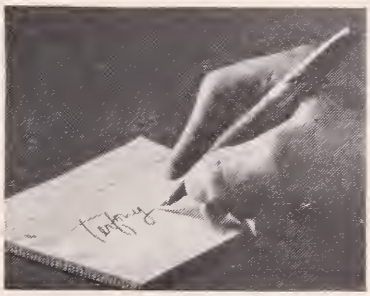

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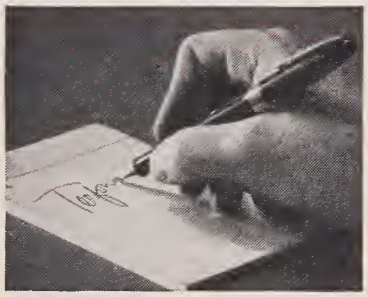

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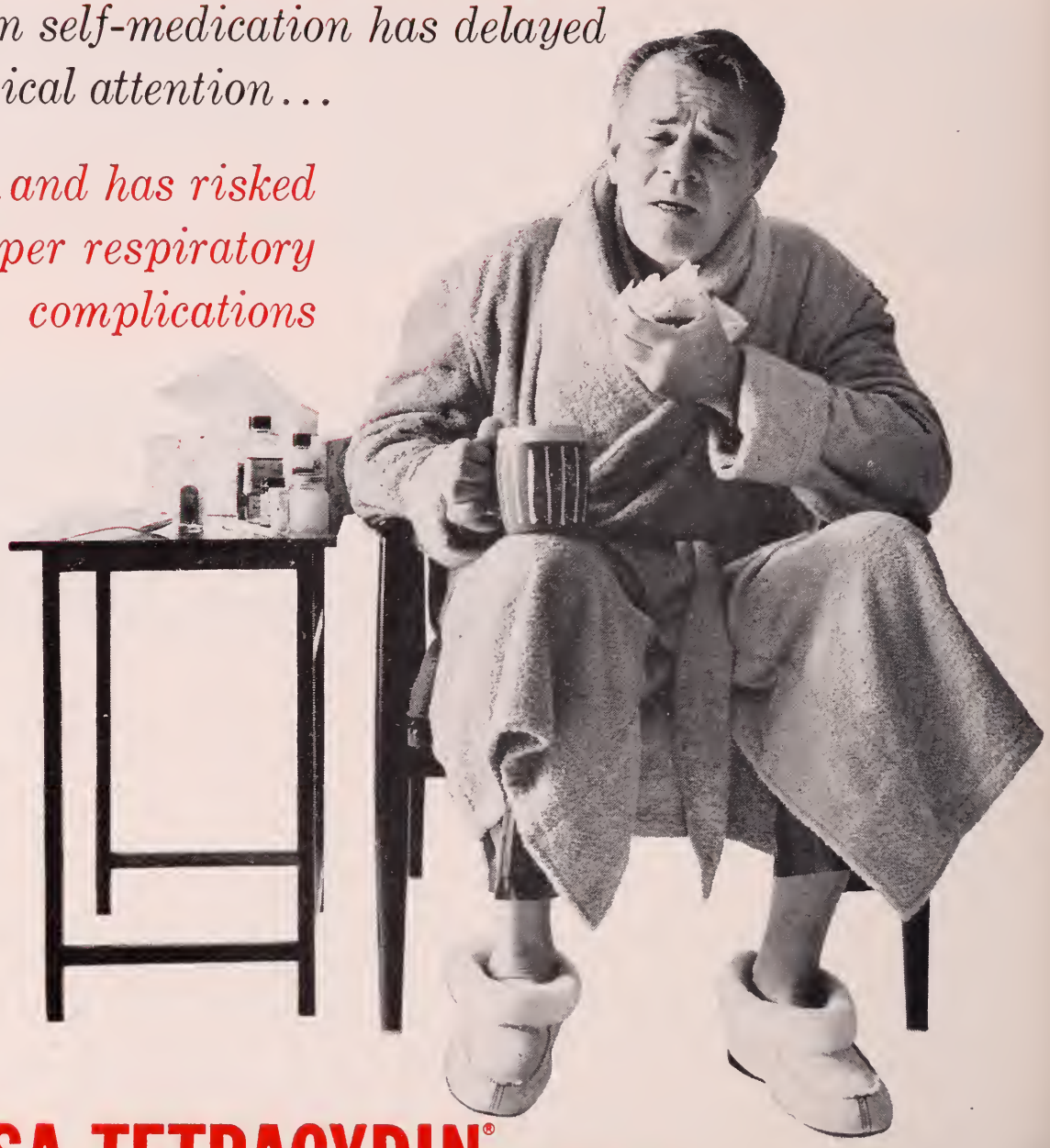

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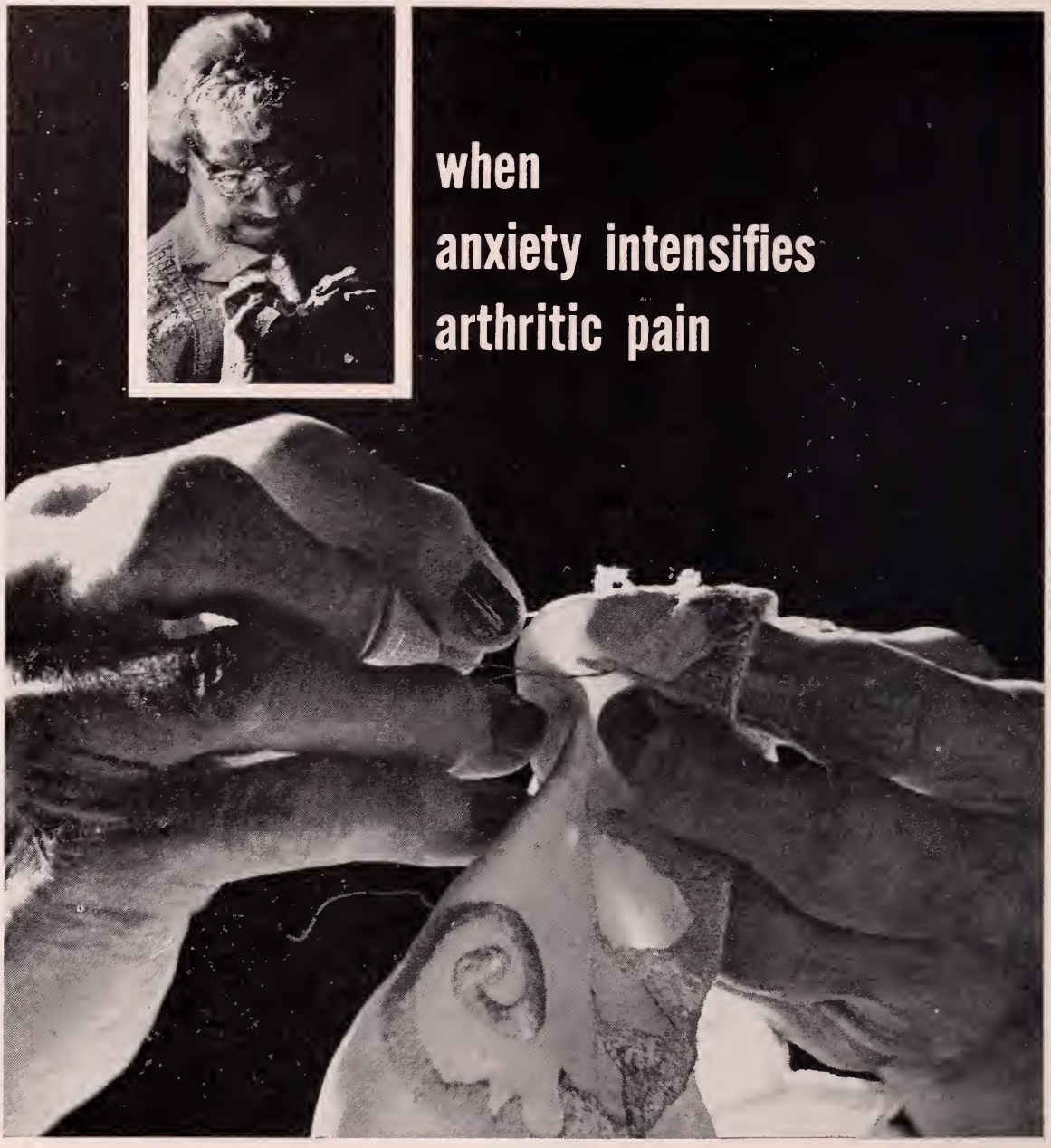

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THE JOURNAL
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Volume XLVI, No. 9, March, 1960

Surgical Therapeusis of the Adrenal Gland

JOHN J. FARRELL, M.D.
MIAMI

With the development of adequate substitution therapy, surgery of the adrenal gland has become part of the armamentarium of the general surgeon. While much knowledge of all the complex functions of that organ remains to be delineated, there are several well established indications for extirpation and still other instances in which, on an investigative basis, adrenalectomy is justifiable. Some phases of this type of endocrine surgery should still be limited to areas where a trained team of investigators is equipped to carry out the myriad observations necessary to explain more fully the role of the adrenal gland. All surgeons, however, should be equipped to extend adrenalectomy to patients suffering specific ills.

The adrenal gland itself consists of two markedly different physiologic parts. The medullary portion produces epinephrine and norepinephrine. The medulla is derived from ectodermal pheochromoblasts along the developing sympathetic ganglionated chain. This portion of the gland is largely under the control of the sympathetic nervous system. The adrenal cortex, on the other hand, is controlled by the pituitary gland. It is derived from mesothelium of the genital ridge and secretes some 28 hormonal substances which are involved in many metabolic processes ranging from protein, carbohydrate and fat metabolism to salt, water and androgenic balance.

Professor and Chairman, Department of Surgery, University of Miami School of Medicine.

From the Department of Surgery, University of Miami School of Medicine and Jackson Memorial Hospital.

Read before the Florida Medical Association, Eighty-Fifth Annual Meeting, Bal Harbour, Miami Beach, May 4, 1959.

The adrenal cortical steriods have in common the sterol nucleus which is the basic structure of many body substances such as sex hormones, cholesterol and bile salts. In general, biologic activity of adrenal character has been most clearly ascribed to those sterols bearing a ketone group at carbon 3 and associated with radicals attached to the 11 and 17 carbon bonds (fig. 1). By and large, the desoxycorticosterones with no oxygen or hydroxyl radicals attached to carbon 11 are associated primarily with electrolyte metabolism, although aldosterone (fig. 2), which has an aldehyde attached to carbon 19, has been shown to have considerable sodium-retaining effects along with causing an eosinopenia and consequently has been called by some investigators "electrocortin." On the other hand, those steroids which have oxygen or hydroxyl group at carbon 11 have a marked effect on carbohydrate metabolism with some effect on electrolyte balance as well as fat and protein metabolism. Examples of these steroids are Compounds F and B, the two 11-hydroxycorticosterones and Compounds E and A, the corresponding 11-oxy-compounds. 11-dehydrocorticosterone or Compound E is the substance generally known as cortisone. The adrenal cortex does not contain large reserves of steroids, but it appears that it can, under normal circumstances, rapidly synthesize these steroids from cholesterol by oxidation of that substance first to pregnenolone and then to progesterone which, with hydroxylation at the 11, 17 or 21 position or combinations thereof, yields the compounds mentioned.

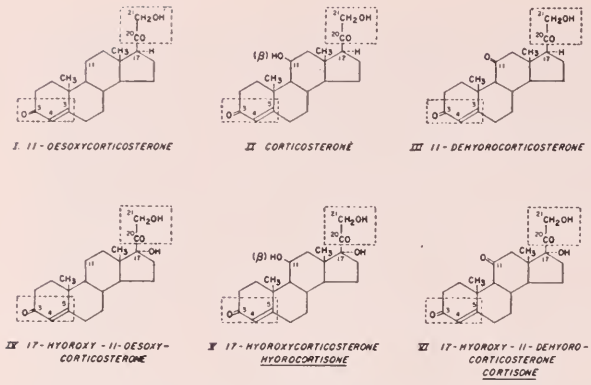

Fig. 1.—Adrenal Cortical Hormones.

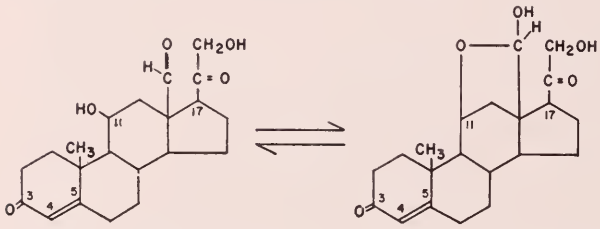

Fig. 2.—Aldosterone.

As a rule, the surgeon is concerned with hyperfunction of the adrenal gland either by tumors of the adrenal cortex or medulla, or hyperplasia of the cortex. Because of the complexity of the cortical secretions, syndromes associated with hypersecretion of cortical tissue show a wide variation in manifestations depending upon age, sex, and amount and type of the predominant hormone secreted. Table 1 is a simple classification of adrenal lesions of surgical significance.

Table 1. — Classification of Adrenal Lesions of Surgical Significance

A. Adrenal Medullary Tumors (Hyperplasia is unknown)
  1. Secretory—Pheochromocytoma
  2. Nonsecretory—Neuroblastoma
     Ganglioneuroma
B. Adrenal Cortex
  1. Hyperplasia—Cushing's syndrome
     Congenital virilism
  2. Tumor—Cushing's syndrome
     Virilizing syndrome
     Feminizing syndrome
     Primary aldosteronism
     Mixed and intermediate syndrome

Medullary Lesions

Hyperplasia such as seen in the cortex is not known. Medullary lesions of clinical significance are tumors either secretory or nonsecretory.

A. Nonsecretory

1. Neuroblastoma is a common retroperitoneal tumor of early childhood. It is highly malignant and cannot be distinguished preoperatively from an embryoma of the kidney. Its signs and symptoms are those associated with a large, fast-growing mass—that is, pain, loss in weight, pallor, fatigue and cachexia.

2. Ganglioneuroma is a more slowly growing tumor of the mature cells with a more favorable prognosis.

B. Secretory

1. Pheochromocytoma (chromaffinoma) produces epinephrine and norepinephrine. About 10 per cent of the tumors of this type are located in aberrant adrenal tissue along the sympathetic chain, and while they may be found in the thorax or elsewhere, they are usually in the retroperitoneal area. Bilateral tumors do occur. These tumors may produce paroxysmal or continued hypertension. Symptomatology associated with these tumors consists usually of severe headache, dizziness, palpitation, sweating, nervousness and precordial distress. Such attacks may last only a few minutes or persist for several days. Pressure and manipulation in the kidney area may produce or precipitate an attack. Richards and Hatch[1] classified pheochromocytomas as follows:

a. Adrenal sympathetic syndrome—paroxysmal hypertension.

b. Sustained hypertension — frequently seen in the young or after pregnancy.

c. Atypical hyperthyroidism with an increased basal metabolic rate, but without thyroid enlargement or other signs associated with hyperthyroidism.

d. Hypertension, mild diabetes and mild hyperthyroidism.

e. Asymptomatic cases in which sudden and severe collapse is experienced following minor surgery or trauma.

Thompson and Arrowood[2] stated that excessive sweating, peripheral vasomotor phenomena (blanching and flushing), elevated temperature of one degree Fahrenheit or more, postural tachycardia and postural hypotension are associated with pheochromocytoma, but not with essental hypertension.

Cortical Lesions

A. Virilizing Syndrome

Congenital virilism is always due to bilateral cortical hyperplasia. Virilism appearing first during adolescence may be due to hyperplasia and oc-

casionally to tumor. Virilism appearing after the neonatal period in childhood is usually due to adrenal cortical tumor and is usually malignant. This latter is true also for virilism appearing in adult life.

The pathologic physiology of congenital virilism involves an enzymatic defect of the cortex. Androgenic or inadequately oxygenated steroids are produced instead of hydrocortisone. Lack of hydrocortisone leads to overproduction of ACTH, adrenal hyperplasia and more intense androgenicity.

The manifestations of virilism vary with age and sex. Intrauterine hyperplasia in the female results in an enlarged clitoris and other bisexual phenomena associated with pseudohermaphroditism whereas in the male it causes macrogenitosomia praecox. Acute adrenal insufficiency may be the initial manifestation with marked dehydration and loss of sodium and chloride. Virilism appearing after the neonatal period in the female produces clitoral enlargement, early appearance of pubic and axillary hair, premature closure of the epiphyses and excessive muscular development. When virilism appears after the neonatal period in boys, it produces precocious puberty, enlarging phallus and the appearance of secondary sex characteristics. The testes are small, and there is no spermatogenesis. Characteristically, virilism in the adult female produces hirsutism, amenorrhea, atrophic breasts, a deep voice and acne.

B. Feminizing Syndrome

This has been described only in the male and produces gynecomastia and sometimes hypogonadism. When it develops, it is due either to a benign or malignant tumor.

C. Cushing's Syndrome

No attempt will be made here to correlate changes in cells of the pituitary gland with this disease. Regardless of the ultimate etiologic factors, the syndrome is associated with hyperfunction of the adrenal cortex either through hyperplasia or tumor. While it is most commonly observed in the adult female, it also occurs in men and in children. There may be considerable variation in the clinical manifestations and in the laboratory data from case to case. Tables 2 and 3 list the clinical and laboratory findings in Cushing's syndrome.

Bilateral adrenal hyperplasia accounts for about 80 per cent of the cases in the adult. Adenoma accounts for some 15 per cent of Cushing's syndrome in the adult while the other 5 per cent is due to carcinoma. When Cushing's syndrome develops in children, it is usually due to carcinoma.

Table 2. — Clinical Manifestations of Cushing's Syndrome

1. Truncal obesity
2. Moon face
3. Cervicodorsal fat—"buffalo hump"
4. Hirsutism—mild to moderate
5. Purplish striae of abdomen and thighs
6. Wasted extremities
7. Thin skin
8. Acne
9. Plethoric appearance
10. Ecchymoses in the extremities
11. Loss of hair and testicular atrophy in men
12. Amenorrhea or impotence
13. Hypertension
14. Psychiatric changes
15. Kyphosis

Table 3. — Laboratory Changes in Cushing's Syndrome

1. Alkalosis
2. Decreased blood chlorides and potassium
3. Lymphopenia
4. Decreased glucose tolerance
5. 17-Ketosteroid excretion may be high, normal or low
6. Osteoporosis frequent and may result in spontaneous fractures

D. Primary Aldosteronism

This interesting entity, first described by Conn,[3] is due to a cortical tumor, usually an adenoma, although cortical carcinoma producing the syndrome has been described.[4] Severe electrolyte imbalance is an essential component of aldosteronism usually producing a severe hypochloremic, hypokalemic alkalosis with tetany and periodic severe muscular weakness. Hypertension is present. Pitressin-resistant polyuria, polydipsia and hyposthenuria are common. There are no other features of hyperadrenalism, and urinary steroid excretion is normal except for increased aldosterone.

E. Mixed and Intermediate Syndromes

Adrenal cortical tumors, especially carcinoma, may give rise to bizarre intergrades of feminizing, masculinizing, Cushingoid or aldosterone-like features.

In general, disturbances of protein metabolism are largely anabolic in the adrenogenital syndrome and catabolic in Cushing's syndrome. Contralateral adrenal atrophy is rare in the more virilizing cases and common in Cushing's syndrome. With adrenal cortical tumors, sustained hypertension of a severe degree is common. Some

adrenal cortical tumors are nonfunctioning and manifest themselves only by considerable increase in size causing symptoms or giving a palpable mass.

Diagnostic Aids in Adrenal Hyperfunction

A. AIDS IN BOTH CORTICAL AND MEDULLARY DISTURBANCES

1. Flat Film of Abdomen.—Rarely an adrenal tumor will show some calcification. Neuroblastoma, ganglioneuroma or a symptom-free large cortical tumor may be visualized.

2. Pyelography.—Intravenous and/or retrograde pyelography may show displacement of the kidney or distortion of the calyces.

3. Presacral Air Injection.—While this is a well established and safe technic, it has not proved too reliable or of major help to us in determining the presence of tumor or the size of the adrenals. It can be combined with laminograms and with pyelography for, potentially, more accurate delineation.

4. Aortography.—Visualization of the adrenal blood supply may be obtained, but often the procedure approaches the magnitude of surgical exploration, and we have rarely employed it in adrenal diagnostic problems.

5. Bone X-rays.—Osteoporosis and wedging of the vertebral column may be seen with Cushing's syndrome.

B. AIDS IN CORTICAL DISTURBANCES

1. Blood Chemistry.—Chloride and potassium are often low in Cushing's syndrome. Alkalosis in this disease is not uncommon. Here also a hypercalcuria is often present as is an elevated blood glucose level. The hyperglycemia tends to be insulin-resistant, and the glucose tolerance curve tends towards the diabetic type. As was mentioned previously, definite electrolyte abnormalities are an integral part of primary aldosteronism.

2. Urinary Hormonal Measurements

a. 17-Ketosteroids.—These may be high, normal, or low in Cushing's disease. (Interstitial cell tumors of testes, some cases of arrhenoblastoma and masculinizing tumors of the ovaries also give elevated levels.) Priestley[5] pointed out that in distinguishing hyperplasia from tumor in the virilizing syndrome the 17-ketosteroid excretion may be depressed with cortisone in hyperplasia but not in tumor.

b. Urinary Corticosteroids.—These measurements are still too complicated for the usual hospital laboratory, but the 11-oxysteroids and hydroxycorticosteroids are usually elevated in Cushing's disease.

C. AIDS IN MEDULLARY TUMORS (PHEOCHROMOCYTOMA)

1. Protein-Bound Iodine and I^{131} Uptake.—Since medullary tumors may be confused with mild hyperthyroidism, these tests may be of considerable value because the uptake is elevated in hyperthyroidism but not with pheochromocytoma.

2. Pharmacologic Tests

a. Provocative Tests.—Histamine, Etamon (tetraethylammonium chloride) and Mecholyl (acetyl-beta-methylcholine chloride) produce abrupt rises in blood pressure. These drugs are used to produce attacks during normotensive periods. They can be dangerous although the availability of Regitine (phentolamine) to control the rise in blood pressure has been a safety precaution; false positives and false negatives are obtained. (Usual technic: 0.025 mg. histamine in 0.5 cc. normal saline intravenously after one-half hour base line blood pressures. Blood pressure readings are obtained every minute for 15 minutes. A sharp rise in pressure of 50 mm. Hg or more systolic and 25 mm. Hg diastolic is considered a positive result.)

b. Adrenolytic Drugs.—These are predicated pharmacologically on their ability to block transmission of sympathetic nerve impulses at the myoneural end plate where epinephrine or norepinephrine may be the chemical transmitter of the impulse. Benzodioxane and Regitine are most commonly used. Regitine appears to give few or no false positives or false negatives. (Technic: 5 mg. in 1 cc. sterile water given intravenously, [0.33 mg./kg. I.V.]. Blood pressure readings are obtained every 30 seconds for three minutes and then every minute for seven minutes; a positive result is a decrease in pressure of 35 mm. Hg systolic and 25 mm. Hg diastolic. No sedative or narcotic is permitted for 24 hours preceding the test. Antihypertensive drugs must be discontinued one to seven days beforehand.)

3. Urinary Catechols.—Normal epinephrine and norepinephrine output in 24 hours is 20 to 40 micrograms. Quantities 10 to 50 times the normal range have been reported with pheochromocytoma. It should be remembered that

ingestion of certain foods such as banana or avocado may cause abnormally high urinary catechol content.[6]

Indications for Surgery.—The indications and contraindications for operative intervention in the various adrenal lesions described are simple: (a) it is to be employed in all instances in which tumor is the underlying cause; (b) the hyperplasia causing congenital virilism is best managed by the administration of cortisone, and surgical removal is contraindicated; (c) in other instances of hyperplasia, including Cushing's syndrome, surgical removal is indicated.

Preoperative Management

A. As in all surgical cases, optimal general status of the patient should be obtained. This includes adequate nutritional status, normal blood volumes and freedom from intercurrent infection.

B. Patients with Cushing's syndrome or primary aldosteronism may show electrolyte disturbances which must be corrected.

C. Three hundred milligrams of cortisone acetate suspension is given intramuscularly the night before operation as a depot dose. We infuse hydrocortisone 100 mg. intravenously in 1 liter of saline during the operation and over the next seven hour period. An additional 100 mg. of cortisone acetate may be given intravenously over another seven hour period if there is trouble maintaining an adequate blood pressure. One hundred milligrams of cortisone acetate intramuscularly should be given every 12 hours for the first three postoperative days. Oral cortisone acetate, 50 mg. every eight hours, should be instituted on the second postoperative day. Cortisone is then gradually decreased over the next week to maintenance dose in bilateral adrenalectomy or to complete withdrawal if one adrenal remains.

Surgical Considerations

Despite all the preoperative tests, it is often impossible to tell on which side a tumor is located and whether one is dealing with tumor or hyperplasia or with unilateral or bilateral tumors. In general, there are four major approaches to the adrenal gland:

A. Anterior abdominal route
B. Transthoracic or thoracoabdominal route
C. Subdiaphragmatic with excision of twelfth rib
   1. Posterior simultaneous bilateral approach
   2. Unilateral approach with patient in lateral decubitus position
D. Classical kidney flank approach

These approaches have their shortcomings as well as their advantages. One should be familiar with each and utilize the approach best suited for the individual case. By and large, the transthoracic approach is reserved for large tumors such as the neuroblastoma or a large cortical carcinoma. The anterior approach is probably best suited in pheochromocytoma where the patient is relatively thin. It gives the best access to bilateral exploration and for search for aberrant adrenal tissue. Palpation alone may not give the necessary information, and it is often necessary to open the peritoneum over the adrenal to visualize a small tumor. The anterior approach may prove difficult in a Cushing's syndrome with a large pendulous abdomen.

Resection of the twelfth rib may give some postoperative neuritic sequelae, but it is an easy approach and allows for thorough search of the retroperitoneal area and along the paravertebral gutter. It is the approach most frequently employed by us. On the right side it gives access more readily to the adrenal vein which drains into the inferior vena cava from the inferior, medioposterior portion of the gland. This vein can prove troublesome although care must also be exercised on the left side to prevent injury to the renal vein since the left adrenal vein drains into it.

The flank incision may be extremely simple at times, but if the gland or tumor rests high up under the diaphragm, exposure may be difficult.

In exploration for Cushing's disease, if an atrophic gland is encountered, one can reasonably expect to find a tumor on the opposite side. The atrophic gland should not be disturbed. If, on the other hand, a normal or hyperplastic gland is encountered, one should either remove about 90 per cent of that gland, leaving a small medial portion, and then excise the opposite gland or, as advocated by Thorn and others, which we have been doing in our more recent cases, perform a complete bilateral adrenalectomy. There is danger in subtotal resection of an incomplete remission or an actual recurrence of the disease.

Pheochromocytoma should be handled with great gentleness and the blood supply ligated

early in order to prevent precipitous hypertensive episodes. The anesthesiologist must have Neosynephrine (phenylephrine hydrochloride). Levophed (1-norepinephrine) and Regitine available constantly for intravenous administration to control hypertensive and hypotensive episodes. If the blood pressure remains elevated after removal of the tumor, one can be certain that bilateral tumors were present.

Postoperatively, two factors are of major consideration: the development of adrenal insufficiency and (with pheochromocytoma) severe hypotensive episodes. If the preoperative, operative and postoperative administration of cortisone is adequately maintained, adrenal insufficiency can be avoided to a large extent. Two types of adrenal insufficiency may be seen: (1) An acute peripheral circulatory failure may occur within the first 24 hours which is usually unresponsive to cortisone but is satisfactorily treated with norepinephrine. (2) The cortisone withdrawal syndrome is characterized by early morning nausea, anorexia, vomiting, weakness, mental disturbances, tachycardia, fever and in some instances a rather violent erythema of the face, neck and/or extremities. Some of the earlier symptoms may initially be precipitated by ambulation and improved by bed rest, but soon become constant. Adequate cortisone administration will correct this.

If a tumor has been removed, it is seldom necessary to continue cortisone over a prolonged period, and the dosage can usually be decreased slowly. If one has removed all of one gland and 80 to 90 per cent of the other for hyperplasia, cortisone must be continued indefinitely with the usual required dosage of about 25 mg. daily.

In Cushing's disease a variable period is required postoperatively for remission of the disease. Priestley[5] stated that this period of time is proportional to the duration and severity of the disease preoperatively. The patient must be made aware, preoperatively, that there will be no sudden and dramatic response and that convalescence may be prolonged and stormy. Large quantities of cortisone may be required initially, and a slow withdrawal may require several months. The patient will feel very sick indeed during the withdrawal period and may be subject to severe mental depression. Since the patient feels better with more cortisone, he may resist continued withdrawal. Unless patients with this syndrome are prepared for this sick period by adequate and repeated preoperative warning, cooperation may be difficult to obtain. It may then be most difficult to effect the withdrawal at a reasonable rate. The low potassium syndrome is an ever present danger during this period and requires a high intake of potassium and other intracellular cations.

Summary

There is a considerable group of adrenal lesions amenable to surgical therapy. The diagnosis and the preoperative and postoperative management depend upon the pathophysiology of the syndrome and either the restoration of a normal adrenal physiologic state or substitution therapy. The biochemical and homeostatic mechanisms involved are of such nature that the ultimate benefit to the patient is obtained only by close cooperation between the endocrinologist, the surgeon and the clinical laboratory.

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Arterial Aneurysms: Florida's Problems

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Arterial aneurysms have long presented formidable problems to those attempting to treat them. They show a very high incidence of mortality and morbidity with the ever present danger of rupture or thrombosis.

During the past several years diagnostic and surgical technics have been developed by which many of these arterial aneurysms, once considered hopeless, can be successfully treated. There are hundreds of articles in the recent professional literature dealing with the surgical technics and results.[1-3] It has been conclusively demonstrated in large series that for those patients with aneurysms of the abdominal aorta and major peripheral vessels resection of the aneurysm and replacement with an arterial graft, when feasible, is the preferred method of treatment. Although the operative mortality is high, comparatively, it offers to many at least a surcease from the prospect of early death that follows most patients in whom these aneurysms develop. For example, Wright, Urdaneta and Wright[4] showed that of those patients with arteriosclerotic abdominal aortic aneurysms only 29 per cent survive two years without surgical treatment. The few available reports of late results following resection and grafting permit us to expect a much better outcome.[5-9]

With the foregoing as background, let us focus our attention on Florida and see what we find and what we may expect. In viewing the population which we serve and its social aspects we find, of course, tourism and retire-ism two of its main features.

Arteriosclerosis is the major cause of aneurysms of the aorta and lower extremities.[1,10] It is most commonly associated with increasing age becoming symptomatic especially in those in the seventh decade and above. The rate of diagnosing abdominal aortic aneurysm was determined in three Florida hospitals: Mound Park and St. Anthony's Hospitals in St. Petersburg, and the Veteran's Administration Hospital at Bay Pines. There were 158 cases in which this disease was diagnosed during 1955-1958, inclusive, the rate being 1.6 per 1,000 patients admitted. This, then, is not a rare disease in these hospitals. Incidentally, I might add that of the 158 patients in the series, 80, or 50.9 per cent died in the hospital, showing us the highly lethal character of this disease. Eighty per cent were 65 years of age or older. The peak decade was the eighth. The oldest patient was 93, the youngest 43. We see, then, that abdominal aortic aneurysm, caused most commonly by arteriosclerosis, is one which affects the older age groups.

The number of persons 65 years of age and older is rapidly increasing in Florida. In 1950 there were 237,000 people 65 and older. According to demographic studies, this group is increasing at a rate of about 5.7 per cent per year. Present population trends indicate a 1960 Florida census of 4.9 million people, with 9 per cent (400,000) aged 65 and over.[11] Thus, by this inference and from the studies of Maniglia and Gregory,[10] we may expect to see more patients with aneurysms as well as the other sequelae of arteriosclerosis.

The following cases are presented to illustrate some of the types of aneurysms that we see.

Report of Cases

Case 1.—A 77 year old white man was admitted to the hospital because of a large abdominal aortic aneurysm, present about four years and demonstrated by physical examination and plain x-rays. (Aortograms are not usually needed in cases of this type.) The aneurysm, extending from 3 cm. below the renal arteries to the bifurcation, was resected and replaced with a nylon bifurcation graft. The aortic graft functioned well. The patient, however, died on the fourth postoperative day from bilateral pneumonia probably caused by aspiration. Figure 1 shows the autopsy specimen with the graft anastomosed to the aorta above and to the common iliac arteries below. The aneurysm lies to the right. The lumen showed the first stages of the usual formation of a new intima, that is, a thin layer of organizing thrombus lining the graft.

Aneurysms of the aorta are, of course, more threatening to life, but there are also arteriosclerotic aneurysms of other vessels, such as the innominate, carotid, iliac, femoral and popliteal arteries.

Case 2.—A 71 year old white man was first seen six months after he began having aching in each popliteal area. Later, swellings developed behind each knee. Examination showed a large pulsating mass in each poplit-

Read before the Florida Medical Association, Eighty-Fifth Annual Meeting, Bal Harbour, Miami Beach, May 5, 1959.

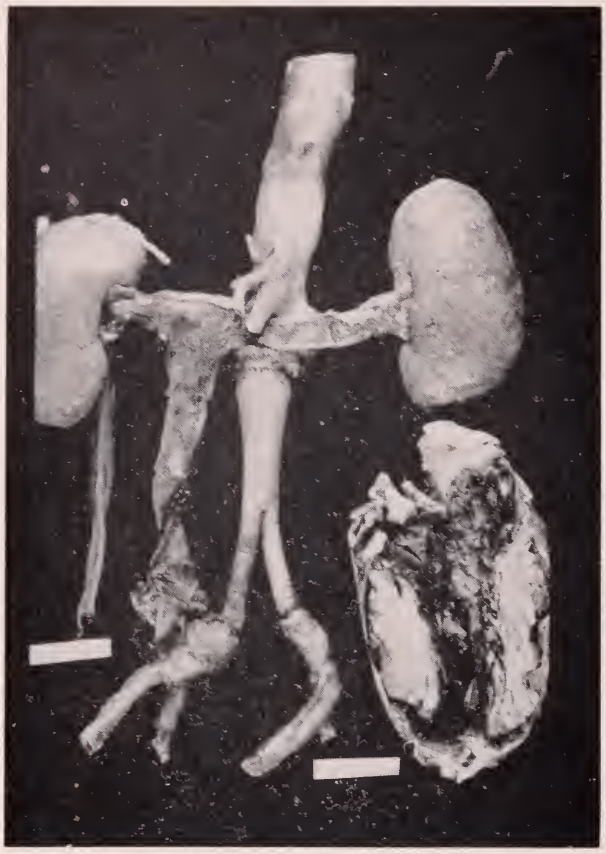

Fig. 1. — Synthetic aortic graft; resected aneurysm to right. (Case 1)

Fig. 2. — Arteriogram, showing dye in the left femoral artery and popliteal aneurysm. (Case 2)

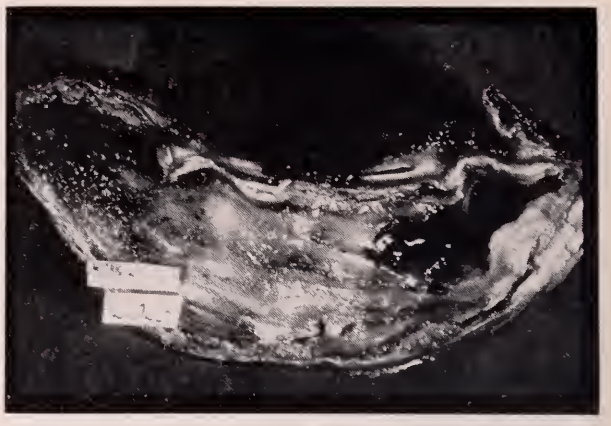

Fig. 3. — Bisected left popliteal aneurysm. (Case 2)

eal area, somewhat larger on the right. Oscillometry and pulses at the ankles were normal. Arteriograms (fig. 2) revealed similar large aneurysms bilaterally and a large distal popliteal artery beyond each aneurysm. It should be noted that this patient was an avid gardener and for two years he had spent much time crouching as he worked with the knees hyperflexed.

In view of the well known dangers of popliteal aneurysms, namely thrombosis or hemorrhage, the patient had excision of the right popliteal aneurysm and a right lumbar sympathectomy performed in June 1957 and a similar procedure on the left six days later. The aneurysm on the right was 19 by 6 cm; that on the left was 18 by 5 cm. The defect in each case was repaired by a crimped nylon graft with end to end anastomoses. The postoperative course was entirely uneventful. The pedal pulses have remained adequate for 14 months.

Pathologic examination revealed the usual laminated thrombus within each aneurysm and a central channel (fig. 3). There was considerable atheromatous change within the walls.

Although trauma is not the usual cause of popliteal aneurysms, it is thought that arteriosclerosis and the repeated trauma of crouching caused these popliteal aneurysms.

Case 3.—A 79 year old white man with diffuse arteriosclerosis and congestive heart failure was admitted to the hospital in December 1958 with bilateral femoral artery aneurysms. The one on the left had ruptured and bled into the retroperitoneal area. There were no pedal pulses. Operation on this very ill man consisted of simply ligating the artery above and below the aneurysm and making a side to end by-pass synthetic graft around the aneurysm. The popliteal pulses remained present postoperatively. With only a 60 day postoperative follow-up, the patient was asymptomatic with regard to his lower extremities.

Whereas arteriosclerotic aneurysms may develop in the older population, there is another type of aneurysm which we see following trauma. The traumatic aneurysms may follow accidents on our much traveled highways, industrial accidents, or trauma such as the next case will show. In a high percentage of cases aneurysms are traumatic in origin. Pratt[12] found 20 per cent due to trauma, and McSwain and Diveley[13] reported 10 out of 26 arterial aneurysms caused by trauma. The usual pathogenesis involves a penetrating

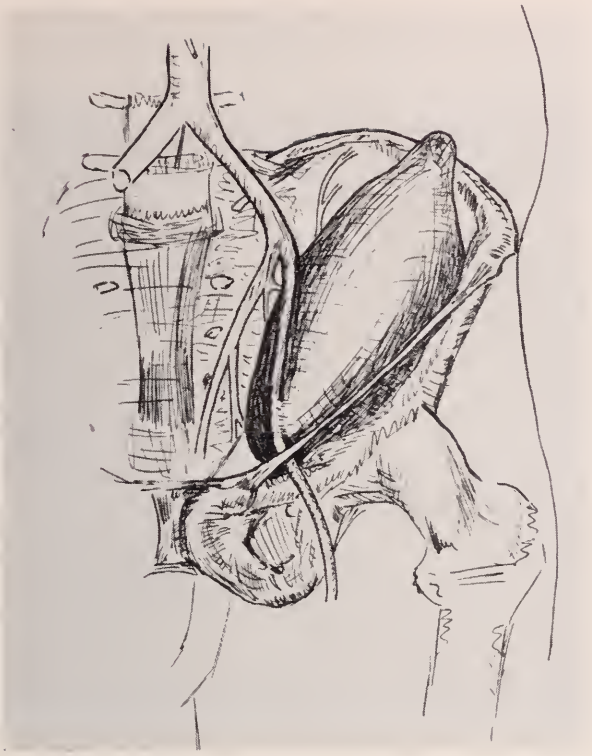

Fig. 4. — Traumatic (false) aneurysm of the left external iliac artery due to injury by fishing pole. (Case 4)

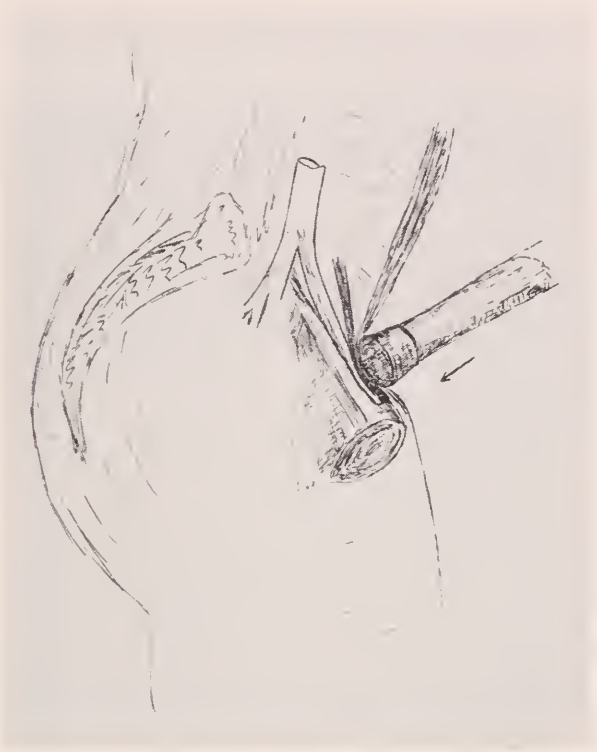

Fig. 5.—A diagrammatic concept of the manner in which the arterial injury occurred. (Case 4)

injury to the artery, resulting in immediate or delayed hemorrhage into the surrounding tissues which then form the walls of the false sac.

Case 4.—A 43 year old fisherman was hospitalized in November 1957 with complaints of sudden onset of swelling in the left lower quadrant of the abdomen and severe persistent pain radiating into the scrotum. Previously, he had been in excellent health. There had been no blow nor other known injury to the area. Physical examination revealed a slender, well developed white man with a 10 by 10 cm. firm, nontender mass in the left lower quadrant adjacent to the inguinal ligament. There was a systolic bruit over the mass and a thrill in the left femoral artery. Pedal pulses were normal. The right femoral pulse was normal; the left was slightly decreased.

Laparotomy showed the mass to be an extensive aneurysm. Accordingly, on December 11, via a left paramedian incision, a huge pulsating 12 by 18 cm. false aneurysm was exposed, lying retroperitoneally in the left pelvic and lumbar gutter (fig. 4). There was no arteriosclerosis. The distal aorta, the common and external iliac arteries and the femoral artery were dissected out. The source of the aneurysm was found to be a 2 cm. longitudinal defect in the left external iliac artery. The neck of the sac was divided, and the wall of the artery was sutured with continuous 5-0 arterial silk. The posterior parietal peritoneum which formed the anterior wall of the false sac was opened and evacuated of blood and thrombus. This area was widely drained through a stab wound. The postoperative course was uneventul. There remained excellent pedal and femoral pulses with no thrill. He has remained asymptomatic 12 months following the operation except for some weakness of the left quadratus femoris.

Since an aneurysm such as this is seen following some sort of trauma, the patient was repeatedly questioned concerning a blow or other injury to the area. He steadfastly denied any injury. Since fishing was his vocation and avocation, he was asked in what manner he handled his pole while fishing. He recalled that he habitually placed the butt of the pole firmly in the left groin area and indicated the area just above the left inguinal ligament. Much of his fishing had been for tarpon, a large active game fish found especially in Florida waters. Tarpon fishing regularly requires heavy tackle with considerable force upon the butt of the pole. Figure 5 shows the common iliac and external iliac passing beneath the inguinal ligament, over the ramus of the pubis and into the femoral sheath. This reconstructs the injury as we suppose it to have happened, that is, with the butt of the pole impinging upon the fixed iliac artery and tearing it.

It is believed that the trauma illustrated was responsible for the injury in the vessel wall which later burst open, causing the acute symptoms. There was a delay of more than two weeks between injury and onset of symptoms. This has been reported in other cases.[11] It is important that physicians be aware of the hazards of trauma in this anatomic region, especially in these areas where big game fishing is practiced as a sport or as an occupation. This particular injury could well have been prevented by wearing a leather groin protector or the swivel rest provided on the chairs of most of the sport fishing boats.

Summary

Aneurysms are and will be a common problem in our practice.

Surgical technics have been developed to treat aneurysms in most of the cases.

It is our responsibility (a) to diagnose aneurysms, especially those that are asymptomatic, (b) to evaluate for surgical therapy patients with aneurysms, and (c) to have the necessary facilities and trained personnel to provide surgical correction for these patients.

This study was supported by the Suncoast Heart Association.

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Discussion

DR. HAROLD C. SPEAR, MIAMI: I am privileged to discuss Dr. Hubbell's timely paper on aneurysms. The incidence rate of abdominal aortic aneurysms of 1.6 per 1,000 hospital patients is of interest. This confirms our clinical impression of the frequency of this condition. As Dr. Hubbell has indicated, the importance of abdominal aneurysms is that, if untreated, they are progressive and ultimately fatal usually within one to three years.

One of the most difficult problems with which we all too frequently have to deal is that of the ruptured abdominal aneurysm. Most of us are familiar with the clinical syndrome of the elderly person who suddenly experiences severe abdominal or flank pain, often simulating ureteral colic, and presents clinical signs of shock and a pulsatile abdominal mass. Although it is still possible, by prompt surgical intervention, to salvage up to 50 per cent of these moribund patients, it is of great advantage to operate electively prior to the occurrence of rupture, when surgical resection and grafting can be accomplished at a mortality rate as low as 5 per cent.

The diagnosis can usually be made by careful abdominal palpation alone. If x-ray confirmation is desired, abdominal films will reveal the aneurysmal mass, often outlined by the so-called eggshell calcification.

Abdominal aortography is generally unnecessary and may even be misleading in that only the central channel is visualized and the aneurysmal sac, which is invariably lined by laminated thrombus, does not appear.

I would urge that all patients with abdominal aneurysm, whether or not symptomatic, should be evaluated for operation. Age of itself is not a deterrent, and only those patients who exhibit renal insufficiency or severe associated cardiovascular or cerebrovascular disorders should be categorically denied surgical treatment.

I would like to congratulate Dr. Hubbell on his excellent results in the cases of the bilateral popliteal and the femoral aneurysms. Although popliteal aneurysms were often managed satisfactorily by preliminary lumbar sympathectomy followed by aneurysmectomy, the current practice of re-establishment of vascular continuity by graft replacement avoids the problem of vascular insufficiency which not infrequently occurred.

The traumatic aneurysm of the left iliac artery is a most fascinating problem. I had not appreciated that big game fishing could entail a certain hazard of injury to the femoral and iliac arteries. I am sure all of us will heed Dr. Hubbell's recommendations in this regard.

On the Unrecognized Double Cross

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The theme to be set forth in this communication relates to the many disorders which are seen in day-to-day practice that are either initiated or aggravated by the ubiquitous habit of crossing the legs over the knee and patella, and wherein this factor is not appreciated.

Any apologies that might appear to be in order because of this very simple message are obviated by the following three considerations: (1) the infrequency with which this factor is given any attention whatever by clinicians; (2) the important prophylactic and therapeutic issues involved; and (3) the rarity with which reference is directed to the possible sequelae of leg crossing in the literature. Many physicians are undoubtedly familiar with them, but possibly erroneously believe that the relationship is too "obvious" even to mention to their colleagues.

On the basis of my observations and experiences in a medical and consultation practice, I should like to list briefly some of the significant complications which I believe can on occasion stem from this extraordinarily common habit.

Arterial Occlusive Vascular Disease

Measurements of the skin temperature and of the blood flow with plethysmographic apparatus by many observers have conclusively demonstrated that local pressure of any magnitude above 10 mm. Hg reduces the blood flow in direct proportion to the amount of pressure applied. There can be little doubt that persons with Buerger's disease, the Leriche syndrome, or ordinary arteriosclerotic occlusion of the lower extremities probably compromise their circulation even further by both the vascular kinking and the pressure exerted onto these vessels in the course of leg crossing. For example, one of my patients, a 60 year old man with arteriosclerotic obliterative disease of the lower extremities in whom barely perceptible deflections on the oscillotonometer could be obtained in the midleg areas bilaterally, is unable to cross his legs more than 30 seconds without the onset of severe ischemic pain. It is even possible that the concomitant prolonged flexion of the thighs can influence the areas of vascular involvement in aortoiliac occlusion (the Leriche syndrome).

Following the rousing of my interest in this problem, I have obtained the oscillometric index with the legs both parallel and crossed in numerous patients presenting themselves to me with a variety of vascular and other disorders of the lower extremities. The Propper oscillotonometer (von Recklinghausen) was employed. Pulsometric readings (P.R.) were generally obtained with the cuff in or above the midleg position. (The pulsometric readings in this position normally range from 3 to 10.) Very significant decreases in the pulsometric readings were readily demonstrable in over 75 per cent of these patients. Several representative cases may serve to illustrate the marked impediment to the flow of blood in the lower extremities that can be induced by leg crossing.

A 69 year old man with a diabetic neuropathy exhibited a decrease in P.R. from 15 in the sitting position to 2 and 3 with the legs crossed.

A 69 year old woman with arteriosclerotic vascular disease showed a decrease in P.R. of from 8 in the sitting position to 2 and 4 with the legs crossed.

A 59 year old woman with arteriosclerotic heart disease and paresthesias of the lower limbs had a decrease in P.R. from 12 and 14 in the sitting position to 5 and 7 with the legs crossed.

A 33 year old man with probable Buerger's disease exhibited a decrease in P.R. from 5 and 7 in the sitting position to 1 and 3 with the legs crossed.

The universal emphasis on rest, abstinence from smoking, reflex heat, anticoagulants, vasodilators, and sympathetic surgery in the management of arterial occlusive vascular disease stands in striking contrast to the infrequency with which advice concerning the avoidance of this habit is mentioned. In fact, I am not personally aware of any recent paper dealing with occlusive vascular disease wherein this recommendation is made. The ever increasing emphasis upon geriatric care further enhances the import of such advice in sedentary elderly patients with impaired circulation.

Venous Stasis and Edema

Little imagination is required to appreciate the impediment to the egress of blood from the limbs

at, or slightly below, the popliteal level as a result of leg crossing. This is all the more apt to be the case in persons who have the following disorders: (1) a chronic arthritic or periarthritic process affecting the knees; (2) acquired lymphedema or a postphlebitic syndrome; (3) varicose veins, previous congestive failure, or anasarca due to various causes; and (4) pressure in obese women who constantly wear tight garters on the legs or thighs, or closely fitted corsets that press into the groin.

Phlebothrombosis and Thrombophlebitis

I am convinced that a traumatic phlebitis can result from the pressure of the patella on the superficial and deep veins of the legs. Furthermore, pulmonary embolism may be the first evidence of such unrecognized vascular injury. Persons with long legs and pregnant women are especially vulnerable to this hazard. I have seen a number of patients who were thought to be manifesting symptomatic thrombophlebitis due to an abdominal neoplasm, a blood dyscrasia, or an angiitis because of a recurrent phlebitis in whom—after much study and prolonged observation—habitual crossing of the legs appeared to be the fundamental cause. Mention should also be made of two other situations that favor these sequelae owing to the limbs being maintained crossed for long periods of time. These are prolonged trips and television viewing. Another frequently overlooked cause of trauma to the calves is the habit of sitting with the legs flexed and compressed tightly against the under edge of a chair.

Traumatic Neuropathy and Traumatic Myositis of the Lower Limbs

Patients who complain of numbness, paresthesias, and frequent leg cramps at rest when no overt disorders of the feet, the spinal cord, or the arterial perfusion of the limbs can be demonstrated should be queried about the habit of crossing their legs. The trial use of parenteral vitamin B_{12} may be beneficial. On the other hand, this response might be misleading, particularly in elderly persons, inasmuch as the diagnosis of atypical combined system disease could be entertained if such a therapeutic effect is forthcoming.

It is conceivable that many instances of sciatica or of meralgia paraesthetica may also be induced by either the compression or stretching of the involved peripheral nerve in the course of leg crossing. Particular reference should also be made to pressure paralysis of the peroneal nerve ("leg-crossing palsy"), a well defined entity.[1] This mononeuropathy results from the compression of the common peroneal nerve between the head of the ipsilateral fibula and the external condyle of the heterlateral femur and the heterolateral patella. In addition to numbness, hypalgesia and other sensory phenomena, there may be a "steppage gait" produced by the foot drop, since the deep peroneal branch innervates the dorsiflexors of the feet and the extensors of the toes. This disorder is particularly prone to occur either in tall, slender persons with long legs, or in middle-aged or elderly persons who have lost much weight and then habitually cross the legs in their inactive state.[2] I have encountered several instances of this disorder wherein the patient became extremely apprehensive over the possibility that a stroke might have occurred. At times, there may be a dissociated type of paralysis in which the involvement affects primarily the motor component. (It is known that the larger motor fibers are usually the first to be affected when a mixed nerve is subject to pressure. (Undoubtedly, there have been instances wherein such a peroneal neuropathy has been attributed to the residual of poliomyelitis[1] or to a herniated intervertebral disk.

There are two additional disorders involving the muscular and neuritic structures of the lower extremities which my personal observations have led me to believe can be caused or aggravated by continual leg crossing. These include night cramps and the so-called restless legs syndrome. In several patients with previously known cerebrovascular disease, the latter disorder largely abated following contradiction of this habit after they had been led to believe that it was due solely to their original neurologic insult or nervous state.

Traumatic Urethritis and Cystitis in Women

There are obviously many factors to be considered in women who present themselves with dysuria and urinary tenesmus. These include local hygiene (especially the wiping forward from the anus to the vulva) and genitourinary tract infection. Nevertheless, the recurrence of these complaints in the absence of any other discernible local pathologic conditions may be largely due to the irritation of the female urethra by leg crossing. Accordingly, it might be preventable to some extent by contradicting this maneuver. In my own practice, I have satisfied myself that stressing this feature has prevented or reduced the incidence of recurrent cystitis and urethritis in a number of patients. Any simple measure of this sort that

could reduce the alarming incidence of unrecognized infection of the renal tract in women must be seriously considered by physicians.

Traumatic Orchitis

Within a short period, I have observed three instances of severe inflammation of the testicle, all on the left side, in men who persistently crossed their legs. These patients were also found to have enlarged and congested prostates. While it would be misleading to imply that leg crossing is the cause of nonspecific prostatitis, one must still consider the possibility that this maneuver aggravated the vascular or lymphatic stasis, or both, resulting from a previous unrecognized prostatitis. This, in turn, probably rendered these men more susceptible to a retrograde vascular and infectious process within the scrotum.

Torsion of the Spermatic Cord

There have been several instances in which torsion of the spermatic cord occurred shortly after a man had crossed his legs.[3] It is highly important to consider this diagnosis early inasmuch as a delay of but a few hours could make the difference between the retention of a viable, functioning testis and a necrotic, hemorrhagic organ requiring excision. One should suspect its presence when an exquisitely tender testis is found high in the scrotum and when the pain is not relieved by elevation of the scrotum (Prehn's sign). This contrasts with the relief to be expected by such a maneuver in the case of other inflammatory conditions involving the intrascrotal contents. It must be distinguished from a strangulated hernia, traumatic orchitis, other forms of acute orchitis, acute epididymitis, and torsion of the appendix testis. This disorder tends primarily to affect incompletely descended testes or those with anomalous attachments within the tunica vaginalis.[4]

Aggravation of Arthritic and Periarthritic Disorders Involving the Knees, the Hips, and the Patella

Over the years, I have again and again noted that repeated crossing of the legs in patients with osteoarthritis and rheumatoid arthritis affecting the knees and even the hips appears to be an aggravating factor in the continuing activity of the underlying process and the resultant disability. A similar aggravating effect by the physical trauma and stretching of the surrounding soft tissues created by this habit occurs in the presence of active periarthritic disease. The general consensus currently emphasizes the role of repeated minor traumata ("microtraumata" with no overt associated hemorrhage, exudation or necrosis) in the etiology of degenerative joint changes by virtue of damage to the internal cartilages and ligaments with impairment of the joint structures and circulation; and also in the causation of such nonarticular rheumatic disorders as bursitis, capsulitis, tenosynovitis, and reflex sympathetic dystrophy.[5] It is especially important to focus attention upon the prevention of such superimposed injuries to a knee joint or a hip that had previously been acutely traumatized in order to minimize progressive fibrosis, thickening of the joint capsule and ligaments, the ensuing contractures and deformities, and splitting or detachment of the articular cartilage. The same applies when a neuropathic arthropathy of the knee exists.

Another potential orthopedic complication from repeated crossing of the legs consists in the reactions of the patellar cartilage to such continual stress, strain, pressure, and disturbed joint mechanics, particularly if there has been significant antecedent trauma to this structure. These consist of local softening, gradual unmasking of vertical fibrils, and loss of hyaline matrix with early fissuring or splitting. There may then ensue a rapid disintegration of all or part of the articular bed (chondromalacia), fracture of the local cartilage or osteochondritis dissecans with separation of a large fragment of cartilage, or a gradual thinning of the entire articular cartilage with erosion down to the bone.[6]

The aforementioned disorders do not exhaust the list of those conditions which may be aggravated by leg crossing. For example, I have observed that a chronic neurodermatitis involving the popliteal areas can be predictably aggravated by this maneuver, particularly if certain types of fabric in the trousers are worn. I recently saw a thin 48 year old woman with long-standing hypertension and persistent so-called hypertensive ischemic ulcers over the lateral lower portion of the legs who would reflexly cross her legs after sitting down. One may also conjecture as to whether minor pathologic states of the anus or rectum, herniation of the intervertebral disks and coccygodynia could bear a cause-and-effect relationship to habitual crossing of the legs in certain patients. Alarming bleeding from rupture of benign scrotal hemangiomas is another complication of leg crossing.

Even when debatable, however, the utter simplicity of recommending that persons with any of the disorders mentioned in this communication either avoid the habit completely, or merely cross the lower limbs at the ankles, has much merit. Where a predisposition already exists to vascular, neuritic or arthritic disorders in the lower extremities—as is well exemplified by persons with long-standing diabetes—such advice may have as much practical importance as that concerning proper foot hygiene and other measures.

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Carcinoma of the Cervical Esophagus Case Report and Review of Literature

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The progress in treatment of carcinoma of the esophagus has paralleled the achievements in thoracic surgery, anesthesia, and electrolyte management. As progress has been made in these ancillary fields, more courageous approaches for management of esophageal lesions have been attempted, and results have been improved in ever increasing proportions.

Malignant lesions in the cervical esophagus have produced problems of their own because of the variance in their lymphatic drainage, local extension, and increased complexity in the type of therapy involved. Since they are located in the neck, or extend into the upper thorax, there has been a constant temptation to handle such lesions entirely through the neck in order to avoid the added risk and difficulty of a thoracic procedure. Indeed, the first successful resection of a carcinoma of the cervical esophagus was performed entirely through a cervical incision by Czerny[1] in 1877. The distal esophagus was sutured to the skin for feeding purposes, but the patient died of recurrence 15 months after the original operation.

By the year 1908[2] there had been 25 local resections of the cervical esophagus reported. The problem of restoring intestinal continuity was lagging behind the zeal for removal of the primary lesion, because of the difficulty and high mortality of any attempts at reconstruction. This mortality was as high as 48 per cent, and the aversion to this operation is easily understood. Sporadic successful cases were reported in the literature, but emphasis was directed toward correction of lesions of the lower and middle third of the esophagus. Many ingenious procedures were described for excision of the intrathoracic esophagus, and for restoration of the alimentary tract. The famous but now unused procedure devised by Torek[3] in 1926 was an ingenious construction of an extrathoracic skin tube connecting the cervical esophagus and the stomach. This was followed by a number of technical triumphs by Raux, Rhinhof, Harrison, Udin and others,[4] who utilized variations of skin grafts, jejunal transplants, and colon transplants.

The first giant step forward occurred in 1938 when Adams and Phemister[5] performed the first successful cardioesophagectomy in this country. In 1940 the first esophagectomy was performed at New York Memorial Hospital; and characteristic of the rapid increase in the volume of such surgery, 150 resected cases at the same institution were analyzed in 1954.[6]

Through the early '40s and '50s a definitive approach developed for the lesion located in the thoracic esophagus. It is now accepted that a total esophagectomy or subtotal esophagectomy with an esophagogastrostomy performed either

through the right or left side of the chest and combined with or excluding an abdominal incision be elected for lesions in this location.

The situation with carcinoma in the cervical esophagus is not so clearcut. Fully 20 per cent of all carcinomas of the esophagus lie in the cervical portion. Wookey[7] in 1942 reported four successful cases in which he resected the lesion and reestablished continuity by performing a staged procedure in which a skin tube was utilized to bridge the resulting defect. One of these patients survived for two years. In 1948 Garlock,[8] and Sweet[9] a few months later, reported the first cases of resection of the entire thoracic esophagus with anastomosis of the stomach to the cervical esophagus. Watson and Pool[10] in 1948 were able to follow seven cases of resection, in four of which the patients were living, one seven years after the definitive operation.

Resection of the cervical esophagus itself with reconstruction of any type is still subject to poor end results. As with all squamous cell carcinomas in other levels of the esophagus, the intramural spread is often extensive. Distal extension is not so important as proximal extension because of the possible necessity of combining the esophagectomy with a laryngectomy. Failure to do so in highly placed lesions may result in early local recurrence. Fully 20 per cent of all cervical lesions[11] will have clinical evidence of metastatic disease at the time of discovery. Early involvement of the paratracheal and deep cervical nodes occurs with involvement of endothoracic nodes being noted later in the course of the disease. Mention will again be made of this factor in the management of the disease.

Symptomatology

Unfortunately, carcinoma of the esophagus, as with esophageal carcinomas at lower levels, remains asymptomatic until the disease has been present for long periods. It is only when obstruction to the passage of food occurs that the patient seeks treatment. Dysphagia then is the commonest symptom of which the patient complains. There is usually accurate localization as to the level where food lodges. Involvement of local organs adjacent to the esophagus accounts for other symptoms such as hoarseness, difficulty in breathing, pain in the neck or ear, or presence of a mass. These are late signs and indicate the fairly advanced but not necessarily inoperable disease.

Management

Since most of these lesions occur from the fourth to the eighth decade, the associated diseases of age must be evaluated and corrected when possible. Dehydration, inanition, hypoproteinemia, anemia, electrolyte imbalance, and diminished blood volume should be corrected when possible. Attention to and correction of any remediable cardiac, respiratory or renal problems should be effected.

The criteria of operability vary. Certainly all lesions localized to the esophagus should at least be explored. More advanced lesions require individual consideration. Extension into the trachea and larynx may necessitate simultaneous laryngectomy, but does not indicate inoperability. Unilateral cervical lymph node metastases may require a simultaneous radical neck dissection, but again need not signify inoperability.

It is logical to assert that an early lesion of the esophagus should be treated by segmental resection of the esophagus, with attention to adequate resection above and below the primary tumor. Reconstruction here will be best effected by the method of Wookey[7] or its modifications. This often necessitates multiple procedures and prolonged hospitalization. It also fails to encompass one aspect of the lymphatic dissemination of the disease, namely, to intrathoracic lymph nodes. Thus adequate surgical measures in the neck may be doomed to failure because of metastases already present within the chest.

A partial esophagectomy with end to end anastomosis would be an ideal reconstructive solution to the problem, but unfortunately adequate resection has not been feasible experimentally in dogs[11] or within the thorax of humans. Kaye and Brown[12] reported seven cases in which as much as 5 to 7 cm. of esophagus could be resected and reanastomosed without requiring mobilization of the stomach. They even recommended the preservation of the distal 10 to 15 cm. of the esophagus in the case of higher lesions in order to preserve the esophageal cardiac juncture. The cervical esophagus cannot be mobilized sufficiently for adequate resection and then reanastomosis.

Although jejunal transplants and colonic transplants have been utilized extensively for thoracic esophageal lesions, they are not feasible in the cervical lesion because of the extent of mobilization necessary.

The procedure which seems to have the most merit, then, would be total esophagectomy with

cervical esophagogastrostomy or pharyngogastrostomy. Accompanying laryngectomy should be performed when indicated by the degree of extension. Radical neck dissection would have to be carried out at a later date when indicated because of the extent of the primary operative procedure.

The cervical lesion should be exposed through a longitudinal incision paralleling the anterior border of the sternocleidomastoid muscle. This will confirm the extent of the lesion and its resectability. Right-sided or left-sided thoracotomy has its adherents. Garlock and Klein[13] preferred a left-sided approach. The proponents of the right-sided approach include Watson, Luomanen and Goodner,[6] Harrison and Pickett[14] and MacManus.[15]

Those who favor a left-sided approach argue that mobilization behind the aortic arch is not insurmountable if one is experienced. It is also thought that mobilization in the stomach without the necessity of an abdominal incision is facilitated on this side. Extensive mobilization of the stomach prior to opening the right side of the chest may be unnecessary in the face of pulmonary or thoracic cage metastases.

Proponents of the right-sided approach think that there is a more direct approach to the thoracic portion of the esophagus with the azygos vein being the only intervening structure. The aortic arch area is much more easily mobilized. Diaphragmatic function may be maintained since the mobilized stomach may be placed in the thorax through the hiatus rather than through an incision in the left leaf of the diaphragm, as is essential from the left side. The argument is not settled. Both sides may be utilized, and one's own experience will in the end dictate the elective approach.

Resection of the esophagus must be performed with a wide proximal margin in order to encompass the proximal submucosal extension. When necessary, the larynx must be sacrificed and the pharynx utilized in the anastomosis. The problems and safeguards to the mobilization of the stomach have been adequately discussed elsewhere,[8] and these must be emphasized. Esophagogastrostomy is best achieved by resection of the 25 cent-sized hole in the anterior wall of the mobilized stomach and performance of a two layer all interrupted silk esophagogastrostomy. The outer layer will bring muscularis of the esophagus to the serosa of the stomach, and the inner layer will unite mucosa to mucosa. One should attempt to invaginate this anastomosis in order to afford greater protection to it while healing.

The postoperative care of the patient corresponds to the management of any patient with a thoracotomy and esophageal resection. Tracheostomy should be performed for all cervical lesions and will simplify greatly the management and prevention of postoperative pulmonary complications. Drains should be placed near the anastomosis and brought up through the neck to allow egress for the complication of anastomotic leak. A thoracotomy tube should be left in place for at least four or five days and managed as in the practice of any thoracic operation. A Levin tube should be left in-dwelling after the operation in order to control the inevitable gastric retention and atony accompanying the extensive stomach mobilization which is required. Pyloroplasty has never been proved to be a necessity in spite of the fact that a complete bilateral vagectomy has been performed.

The mobilized stomach will be brought into the chest on either the right or the left side. In cadavers, Shefts and Fischer[16] showed that the shortest route for the stomach is through an opening in the mediastinal pleura above the aortic arch just posterior to the left subclavian artery. Sweet[9] recommended resection of the medial half of the clavicle and the first rib in order to provide more room for the stomach. This has not been found to be essential by subsequent observers and was not done in the case reported herein.

The patient should receive antibiotics postoperatively and swallowing, even of saliva, should be prohibited. Gradually increasing alimentation is started on the fourth postoperative day, and once swallowing has returned to normal, the tracheostomy tube may be removed. This may take considerable time because in the high resection the swallowing mechanism is disturbed, and it may take as long as two weeks before the patient will be able to swallow normally without aspiration. The patient should be instructed never to lie in the supine position in order to obviate gastric regurgitation and aspiration pneumonia.

Results

The results in the treatment of carcinoma of the esophagus are not good. Many surgeons argue that an over-all five year survival of 27.2 per cent[13] is not adequate, but we think that this can be refuted. The results in lesions in the cervical

esophagus do not approach this. We were able to locate the reports of roughly 60 cases of cervical esophagectomy. There were isolated reports of 10 to 14 years' survival. This indicates that it is not a hopeless condition, and each year the operative mortality is lessened. No patient should be denied the chance for cure, and one may even argue in favor of the palliation since the agonizing dread of strangulation and drowning due to esophageal obstruction should be avoided at any cost. The over-all statistics of any one series cannot be evaluated since the paucity of cases mitigates against accuracy. An experience of 10 to 20 cases in any one clinic would be extensive to this date.

Report of Case

On the first admission to Mercy Hospital, a 74 year old white woman complained of progressive dysphagia for three and one-half months with food seeming to stop at the thoracic inlet. There was an associated 10 pound loss in weight. Roentgen examination by Dr. Donald H. Altman revealed an obstructing lesion with its upper limits at the level of the second thoracic vertebra. Esophagoscopy was performed under local anesthesia, but no specimen for biopsy was obtained. A second attempt was made under general anesthesia, but was again unsuccessful because of marked scoliosis of the neck. Inadvertent esophageal perforation occurred at this time, but with antibiotic coverage there were no sequelae to this accident.

The patient had a past history of pulmonary tuberculosis with an apparent arrest in 1943 and negative follow-up studies since that time.

Physical examination on admission revealed a pulse rate of 80, blood pressure 130/60, respiration rate 20, and temperature 98.6 F. The patient was a poorly nourished white woman in no obvious distress. The entire physical examination was within normal limits except for hyperresonance over both sides of the chest with decreased breath sounds over the upper levels. There was no enlargement of cervical lymph nodes.

On July 15, 1957 exploration of the neck through an oblique incision paralleling the sternocleidomastoid muscle on the left side was performed. Both the upper and lower limits of the lesion could be exposed through the neck. A frozen section of the tumor revealed squamous cell carcinoma which was entirely restricted to the wall of the esophagus. Accordingly, the patient was turned to the lateral position with the left side up, and through the bed of the fifth rib the thorax was opened. The left gastric arteries and the space between the gastroepiploic arch and the colon were transected, thus mobilizing the stomach. Only the right gastric artery and the right gastroepiploic artery were left intact. The duodenum was mobilized by dividing the lateral peritoneal reflection, enabling the entire stomach to be brought up into the neck. The esophagus was mobilized from behind the aorta and the entire esophagus resected from the esophagocardiac junction to an area approximately 2 cm. proximal to the border of the esophageal tumor. Gastrointestinal continuity was re-established by a two layer all silk esophagogastrostomy. The Levin tube was allowed to pass through the anastomosis. A drain was placed down to the region of the anastomosis. The patient withstood the procedure rather well considering her age and general preoperative condition. The anesthetic was administered by Dr. Maurice P. Cooper, using intravenous Pentathol Sodium, nitrous oxide and Anectine.

The postoperative course was an exceedingly difficult one. On the first two to three days after the operation the patient's blood pressure was most unstable and could be maintained only with continuous intravenous Levophed. Change of position resulted in cardiac arrhythmias. The cardiovascular status stabilized with digitalization with Digoxin and with the passage of time. On July 19, the fourth postoperative day, the Levin tube was removed and the patient started on oral feedings. Initially, she was able to swallow, but after 24 hours any food swallowed overflowed into the trachea. This situation persisted, and on July 22 jejunostomy was performed. One day after this procedure, done under local anesthesia, the patient vomited, and a considerable amount was aspirated. Most of this was removed through the tracheotomy tube. It soon became apparent that there was partial obstruction at the site of the jejunostomy. All gastric secretions were collected and all of this material was refed to the patient through the jejunostomy tube, thus avoiding any electrolyte depletion. On the sixteenth postoperative day roentgen examination of the upper part of the gastrointestinal tract utilizing the Levin tube confirmed a partial obstruction at the jejunostomy site, but all the barium passed through this area in six hours.

As the general condition of the patient improved on tube feedings (a Waring Blender mix of table foods) so did the obstruction decrease. Simultaneously her ability to swallow without aspiration improved. On August 10 the Levin tube was removed, and she was able to maintain herself on a completely oral intake. On August 15, one month after the operation, the jejunostomy tube was removed, and she was discharged three days later.

Since discharge, the patient has been seen on several occasions and throughout the year has been able to take a completely normal diet, including whole portions of meat and vegetables without difficulty. In the thirteenth postoperative month, she experienced a gradual decrease in her ability to swallow, noting that she began to cough after ingestion of food and felt that foods could only go to the middle of the neck before stopping. She was readmitted to the hospital, and esophagoscopy by Dr. Jack Ehrenreich revealed a narrowing of the esophagus approximately at the site of the anastomosis. A feeding tube was inserted under direct vision, and she was then maintained on combined oral and tube feedings.

In November 1958, 16 months after the original operation, the patient was readmitted for excision of a lymph node which contained metastatic carcinoma, undoubtedly from the esophagus. In view of the recurrent disease at the anastomosis and in the cervical lymph nodes, she was started on a course of radiotherapy with radioactive cobalt. She is being maintained on tube feedings exclusively at the present time.

We now have definite evidence of recurrence of this patient's disease, but we believe that the 14 months of complete comfort and her freedom in dietary habits certainly warrant the performance of the extensive surgical measures necessary for elimination or control of this disease.

Summary

A case of carcinoma of the cervical esophagus with total esophagectomy and cervical esophagogastrostomy is reported.

The history and management of such lesions are reviewed.

The operation of combined one stage cervical and left thoracic total esophagectomy with transdiaphragmatic mobilization of the stomach is recommended.

The necessity of accompanying tracheostomy should be emphasized.

All lesions of the cervical esophagus should be resected if the patient and lesion meet with the criteria of operability.

Palliative resection may be considered in view of the inevitable and horrible death in the absence of surgical therapy.

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14. Harrison, A. W., and Pickett, W. H.: One-Stage Multiple Approach Operation for Cancer of Upper and Mid-Thoracic Esophagus, Surgery 28:771-778 (Oct.) 1950.
15. MacManus, J. E.: Combined Left Abdominal and Right Thoracic Approach to Resection of Esophageal Neoplasms, Surgery 24:9-16 (July) 1948.
16. Shefts, L. M., and Fischer, A.: Carcinoma of Cervical Esophagus With One-Stage Total Esophageal Resection and Pharyngogastrostomy, Surgery 25:849-861 (June) 1949.

1680 Meridian Avenue (Dr. Unger)
2759 Coral Way (Dr. Schechter).

ABSTRACTS

Intravenous Urography With Renografin 60%. A REPORT OF MORE THAN 600 CASES. By Louis M. Orr, M.D., James L. Campbell, M.D., and Miles W. Thomley, M.D. J. A. M. A. 169:1156-1158 (March 14) 1959.

In this study intravenous urographic examinations conducted in 654 patients were the basis of an evaluation of Renografin (a 60% aqueous solution of the methylglucamine salt of 3,5-diacetylamido-2,4,6-triiodobenzoate) as a contrast medium, the injection consisting of 25 cc. given over a period of three minutes. Satisfactory films were obtained in 636, or 97 per cent, without serious reactions to the medium. Mild reactions, such as nausea, vomiting, a sensation of itching, flushing of the skin, urticaria, sneezing, and a choking sensation, were reported by a total of 40 patients. On the basis of the high percentage of good or excellent films obtained with Renografin 60% and the remarkably few and mild reactions encountered, the authors concluded that Renografin 60% is a superior contrast agent for intravenous urography in the ambulant patient.

Cancer Detection in Practice. By Chester Cassel, M.D. South. M. J. 52:151-157 (Feb.) 1959.

A questionnaire study of cancer detection as practiced by the 1,040 physicians of Dade County, covering 14 items, resulted in 524 returns, representing a sampling of about 50 per cent of the local medical profession. From his analysis of these returns the author concludes that within the limitations of current diagnostic methods it is apparent that improvement would result from wider use of complete examinations and the routine application of such practical methods as cervical cytology and sigmoidoscopy. He describes what a complete examination includes and makes suggestions to improve cancer detection by practicing physicians. In his opinion, physicians should exercise initiative in telling the patients what is needed and in performing complete check-ups, the profession should make more easily available the materials and services of cytology, and the public should be educated as to the need for more comprehensive examination and the increased cost to be expected. He finds a need for instruction in sigmoidoscopy. Emphasizing that the responsibility for cancer detection rests on each physician with each patient he sees, he urges physicians who examine only part of the patient to see to it that the patient understands what else is needed. It is his prediction that if the individual physician does not perform full service in directing the care of his patients, the public will demand and get public and private group medicine.

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 2411, Jacksonville, for abstracting and publication in The Journal. If you have no extra reprints, please lend us your copy of the journal containing the article.

Eighty-Sixth

Annual Meeting

April 8-11, 1960
Jacksonville

Program of Eighty-Sixth Annual Meeting

General Information

Convention Headquarters

Headquarters are the Hotels Robert Meyer and George Washington where most of the activities are scheduled. Other hotels and facilities will be utilized on Sunday for specialty group meetings and socials.

Registration

The Registration Desk is located in the Windsor South, Hotel Robert Meyer in the technical exhibit area, and will be open from 8:30 a.m. to 5:30 p.m. on Friday, Saturday, Sunday, and on Monday from 8:30 a.m. to 4 p.m. Each member is required to register and obtain an official identification badge before attending any sessions. Guests and ladies are also required to register. There is no registration fee. Printed programs are available at the desk.

Members are urged to present their 1960 plastic membership cards from which both their registration card and badge will be stamped by machine.

President's Reception

The President's Reception will be held in the Sky Room of the Hotel Mayflower from 6:30 to 7:30 p.m. Saturday evening. Tickets will be $2.50 per person available at the Association's Registration Desk in the technical exhibit area, mezzanine, Hotel Robert Meyer, and at designated tables in the lobby of both the Hotels Robert Meyer and George Washington.

Buffet Dinner and Dance

A buffet dinner and dance, sponsored by the Woman's Auxiliary for the doctors and their wives, will be held in the East and West Ballrooms of the Hotel Mayflower at 8:00 p.m. on Saturday evening. Tickets at $10.00 per couple will be available at the Association's Registration Desk in the technical exhibit area and designated tables in the lobby of both the Hotels Robert Meyer and George Washington.

Technical Exhibits

The technical exhibits are located on the mezzanine of the Hotel Robert Meyer and may be visited Friday, Saturday and Sunday from 8:30 a.m. to 5:30 p.m. and on Monday from 8:30 a.m. to 4:00 p.m. The exhibits are an important part of the annual convention and each physician will be well repaid by spending some time inspecting them.

Scientific Exhibits

Many Florida and out-of-state physicians have prepared scientific exhibits to show the results of their work. These exhibits are located in the auditorium of the Hotel George Washington. A list is included in the official program.

Scientific Film Program

A program of scientific films is being presented on Saturday evening beginning at 8:00 p.m. on the Mezzanine of the Hotel George Washington. A list of the films with the starting time for each is included in the official program.

Blue Shield

The annual meeting of Blue Shield is being held at approximately 4:00 p.m. on Friday, following adjournment of the first meeting of the House of Delegates, in the Windsor North, mezzanine, Hotel Robert Meyer. There will be no conflicting meetings and all delegates seated at the first meeting of the House of Delegates are urged to attend. Delegates are active members of Blue Shield.

Golf

Information on the golf tournament will be included in the printed program. Competition will be for the Duval County Medical Society trophy won last year by Dr. Lester A. Russin of Miami Beach and the Orlando Loving Cup won by Dr. Robert G. Gilbert of Tampa.

Members of the Woman's Auxiliary will hold their annual tournament at the Timuquana Country Club with a separate list of prizes, including the Orange County Medical Society Trophy for low gross. Inquiries are welcomed and should be directed to Mrs. William A. McCullagh, golf chairman, 4585 Ortega Boulevard, Jacksonville.

Anglers

Physicians desiring to arrange for fishing trips should contact Dr. Charles G. Chaplin, chairman of the Anglers Arrangements for the annual convention, 1101 Beach Boulevard, Jacksonville Beach, phone CHerry 9-5681.

Convention Committee

A. Judson Graves, Chairman
George M. Stubbs, Co-Chairman—Golf
Charles G. Chaplin, Co-Chairman—Anglers

First Meeting
House of Delegates

Friday, April 8
Hotel Robert Meyer—Windsor North

The Credentials Committee will be available in the lobby of the Hotel Robert Meyer from 11:00 a.m. to 1:00 p.m. for those delegates wishing to register early

Robert Meyer Hotel — Entrance to Windsor North

1:30 p.m. Delegates who did not register earlier will assemble at the Credentials Committee table to present their credentials, fill out their attendance cards, and receive special badges from the Credentials Committee:

Franklin J. Evans, Chairman
Rowland E. Wood
Egbert V. Anderson

Delegates are to occupy seats in the designated section. Other members of the Association and guests are requested to occupy seats in the other sections of the room.

2:00 p.m. President Jack in the Chair

Invocation: Homer L. Pearson, Jr.

Parliamentarian for the President: George F. Schmitt, Jr.

Number of eligible delegates present, report by Franklin J. Evans

Motion to seat delegates if quorum is present

Recognition: President, The Florida Bar, J. Lewis Hall

Recognition: Guests

Approval of minutes of 1959 Annual Meeting as published in July, 1959 Journal

Gavel to Vice President, Eugene B. Maxwell

President's Address: Ralph W. Jack

President resumes Chair

Report: Homer L. Pearson, Jr., Secretary, State Board of Medical Examiners

Reference Committee Personnel announced by President Jack

1. HEALTH AND EDUCATION

English Room

Robert L. Tolle, Chairman
Sidney Stillman
John M. Butcher
Miles J. Bielek
Hunter B. Rogers

2. PUBLIC POLICY

French Room

Edward R. Annis, Chairman
Henry J. Babers, Jr.
Clyde O. Anderson
W. Dean Steward
Eugene G. Peek, Jr.

3. FINANCE AND ADMINISTRATION

Executive Suite

Edward Jelks, Chairman
T. Bert Fletcher, Jr.
C. Frank Chunn
Thomas C. Kenaston
Nelson Zivitz

4. LEGISLATION AND MISCELLANEOUS

Spanish Room

Edward W. Cullipher, Chairman
Walter E. Murphee
Marion W. Hester
Ralph M. Overstreet, Jr.
Robert F. Dickey

Reports of Committee Chairmen and Resolutions:

(Reference Committee No. 1)

Scientific Work, Thad Moseley
Medical Postgraduate Course, Donald F. Marion
Venereal Disease Control, C. W. Shackelford
Maternal Welfare, J. M. Ingram, Jr.
Child Health, Warren W. Quillian
Cancer Control, George W. Morse
Report of Liaison Committee to State Board of Health, James T. Cook, Jr.
Report of Secretary, State Board of Medical Examiners, Homer L. Pearson, Jr.
Resolution: Request for health related activities and programs in public schools

(Reference Committee No. 2)

Conservation of Vision, Marion W. Hester
Medical Economics, Floyd K. Hurt
Medical Education and Hospitals, Thomas O. Otto
Representatives to Industrial Council, P. G. Batson, Jr.
Grievance, Duncan T. McEwan
Nursing, Thomas C. Kenaston
Blood, James N. Patterson

(Reference Committee No. 3)

Address of President, Ralph W. Jack
Board of Governors, Ralph W. Jack
Necrology, Clifford C. Snyder
Advisory to Woman's Auxiliary, Sidney G. Kennedy, Jr.
Councilor Districts and Council, Burns A. Dobbins, Jr.
Advisory to Selective Service for Physicians and Allied Specialists, Corren P. Youmans
Civil Defense and Disaster, Corren P. Youmans
Advisory to Blue Shield, Robert E. Zellner
Medicare Mediation, Burns A. Dobbins, Jr.

(Reference Committee No. 4)

Legislation and Public Policy, H. Philip Hampton
Mental Health, William M. C. Willhoit
State Controlled Medical Institutions, William D. Rogers
Poliomyelitis Medical Advisory, Richard G. Skinner, Jr.
Delegates to A.M.A.

Other business
Announcements
Adjournment

Other Meetings

MEDICO-LEGAL CONFERENCE

Friday, April 8

Robert Meyer Hotel — Windsor Room North
Medico-Legal Conference for members of the Association co-sponsored by the Florida Bar will be held in the Robert Meyer Hotel, Windsor Room North, at 10:00 a.m. on Friday, April 8.

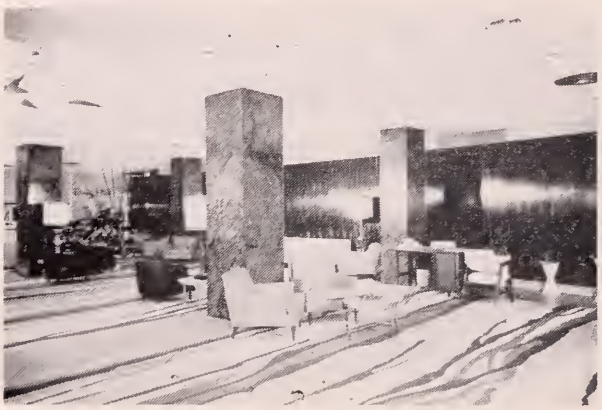
BLUE SHIELD OF FLORIDA

Russell B. Carson, President ..... Fort Lauderdale
John T. Stage, Secretary ..... Jacksonville

Friday, April 8

Robert Meyer Hotel — Windsor Room North
Immediately following adjournment of the first meeting of the House of Delegates

Speaker: John B. Reckless, Duke University Medical Center, Durham, N. C.
"The Facts of Life in the Future of American Medicine."



The lobby of the Hotel Robert Meyer

The lobby of Hotel George Washington

FLORIDA CANCER COUNCIL

Joseph J. Zavertnik, Chairman ..... Miami
Lorenzo L. Parks, Secretary ..... Jacksonville

Friday, April 8

Robert Meyer Hotel — English Room
8:00 p.m. Business Meeting

FLORIDA MEDICAL COMMITTEE FOR BETTER GOVERNMENT

Friday, April 8

Robert Meyer Hotel—French and Spanish Rooms
8:00 p.m. Annual Meeting; Election of Officers
Alpheus T. Kennedy, State Chairman, Pensacola

O. E. Harrell, Secretary-Treasurer, Jacksonville

Social Functions

Friday

ALUMNI AND FRATERNITY LUNCHEONS AND DINNERS
THETA KAPPA PSI

George Washington Hotel—Location to be Announced
12:00 Luncheon
All attending must register with young lady at marked table in lobby.

EMORY

George Washington Hotel—Ballroom
7:00 p.m. Dinner
Speaker to be announced

JEFFERSON

George Washington Hotel — Banquet Hall
7:00 p.m. Dinner
Speaker to be announced

TULANE

George Washington Hotel — Club Room
6:00 p.m. Cocktails
8:00 p.m. Buffet
Speaker: Dr. Maxwell Lapham, Dean, Tulane University School of Medicine

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UNIVERSITY OF GEORGIA

Roosevelt Hotel — Mayport Room
7:30 p.m. Dinner
Speaker to be announced

Scientific Assemblies

Saturday, April 9
Hotel Robert Meyer—Windsor North

FIRST SCIENTIFIC ASSEMBLY

Presiding: Thad Moseley, M.D.

9:15 a.m. **"Fungous Diseases of the Lungs"**

John J. Procknow, M.D., Chicago, Assistant Professor of Medicine, School of Medicine, University of Chicago.

9:35 a.m. **"Treatment of Respiratory Infections in Children"**

Richard T. Smith, M.D., Gainesville, Professor and Chairman, Department of Pediatrics, College of Medicine, University of Florida.

9:55 a.m. **"The Role of Antibiotics in the Management of Infectious Diseases"**

E. L. Foltz, M.D., Philadelphia, Staff Member of the Pepper Laboratory of Clinical Medicine, University of Pennsylvania School of Medicine.

10:15 a.m. **"Griseofulvin in the Treatment of Fungous Infections"**

J. Graham Smith Jr., M.D., Miami, Assistant Professor of Dermatology, University of Miami School of Medicine.

Presiding: John M. Packard, M.D.

11:00-12:00 Panel: **"Recent Developments in the Treatment of Infections"**

Moderator: George T. Harrell, M.D.
Panel Members: Drs. Procknow, Smith, Foltz and Smith

SECOND SCIENTIFIC ASSEMBLY

Presiding: George T. Harrell, M.D.

3:00 p.m. **"Swimming Pool Granuloma,"** Joseph A. J. Farrington, M.D.; Nelson A. Murray, M.D. and Miss Mildred Jeffries, Jacksonville. Presented by Dr. Farrington.

Discussion: Albert G. Lewis Jr., M.D., Tampa
Jack H. Bowen, M.D., Jacksonville

3:25 p.m. **"Parathion Poisoning and Treatment,"** Warren Lindau, M.D. and Roger G. Marcial, M.D., Coral Gables. Presented by Dr. Marcial.

Discussion: Jere W. Annis, M.D., Lakeland
Robert A. Douglas, M.D., Homestead

3:50 p.m. **"Late Results in Vascular Surgery,"** James D. Moody, M.D., Orlando

Discussion: Richard G. Connar, M.D., Tampa
John R. Emlet, M.D., Pensacola

4:15 p.m. **"A Review of 215 Cases of Invasive Carcinoma of the Cervix,"** Curtis W. Cannon, M.D. and Howard C. Duckett Jr., M.D., Jacksonville. Presented by Dr. Cannon.

Discussion: Harold E. Davis, M.D., Miami
Richard W. McDowell, M.D., Jacksonville

4:40 p.m. **"Teamwork in Massive Bleeding Peptic Ulcer,"** Emmet F. Ferguson Jr., M.D. and Harry W. Reinstine Jr., M.D., Jacksonville. Presented by Dr. Ferguson.

Discussion: Lester R. Dragstedt, M.D., Gainesville
James L. Borland, M.D., Jacksonville

5:05 p.m. **"Thoracic and Abdominal Tumors of Infancy and Childhood,"** Albert H. Wilkinson Jr., M.D., Jacksonville.
Discussion: James A. Whiteside, M.D., Coral Gables
Harry M. Edwards, M.D., Ocala

General Session

Saturday, April 9
Hotel Robert Meyer—Windsor North

1:30 p.m. Call to Order

Presiding: Ralph W. Jack, President

Invocation: Rev. Albert J. Kissling, Pastor Riverside Presbyterian Church, Jacksonville

Address of Welcome
Floyd K. Hurt, Jacksonville, President Duval County Medical Society

Introduction of Fraternal Delegates

Announcements

1:55 p.m. President's Guests
Thomas B. Curtis, Webster Groves, Mo., Member U. S. House of Representatives.
Louis M. Orr, M.D., Orlando, President, American Medical Association.

2:30 p.m. Recess to visit exhibits

Other Meetings

Saturday

BOARD OF PAST PRESIDENTS

Saturday, April 9

Robert Meyer Hotel — Section of Cafe Caribe

8:00 a.m. Breakfast
Election of a Chairman and Secretary
Eugene G. Peek, Sr., Chairman and Jere W. Annis, Secretary
(According to precedent, Shaler Richardson will succeed the present chairman and Ralph W. Jack the present secretary.)

REFERENCE COMMITTEES

Saturday, April 9
Robert Meyer Hotel
9:00 a.m. to 12 noon

No. 1 Health and Education—English Room—9:00 a.m.

No. 2 Public Policy—French Room—9:30 a.m.

No. 3 Finance and Administration—Executive Suite—10:00 a.m.

No. 4. Legislation and Miscellaneous—Spanish Room—10:30 a.m.

Social Functions

Saturday

PRESIDENT'S RECEPTION

Mayflower Hotel — Sky Room

6:30-7:30 p.m. No formal program. Tickets $2.50 per person, available at Association's Registration desk during registration hours or entrance to Sky Room prior to Reception; and from designated tables in the lobby of both the Hotels Robert Meyer and George Washington.

BUFFET DINNER AND DANCE

Mayflower Hotel—East and West Ballrooms

8:00 p.m. Buffet dinner and dance sponsored by the Woman's Auxiliary. Tickets are $10.00 per couple, available at Association's Registration Desk during registration hours and at designated tables in the lobby of both the Hotels Robert Meyer and George Washington prior to Saturday noon.

Scientific Film Program

Saturday

Hotel George Washington
Mezzanine A-B

8:00 p.m. "Cold Conization of the Cervix: A Practical Technique for Maximum Hemostasis," J. Allan Offen, M.D., Miami

8:10 p.m. "Open Cardiac Correction of Persistent Partial Common Atrio-Ventricular Canal," Robert S. Litwak, M. D., Miami

8:30 p.m. "Aortic Aneurysms, Resection and By-Pass," Franklin G. Norris, M.D., Orlando

8:45 p.m. "Internal Carotid Artery Endarterectomy," James A. McLeod, M.D., Orlando

9:05 p.m. Smathers-Keogh-Simpson Bill, Florida Society of Internal Medicine, Charles K. Donegan, M.D., secretary-treasurer

Meetings of Specialty Societies

Saturday and Sunday

FLORIDA ALLERGY SOCIETY

James H. Putman, President ..... Miami
I. Irving Weintraub, Pres.-Elect ..... Gainesville
Benjamin A. Johnson Jr., Secy-Treas. Jacksonville

Sunday, April 10
Roosevelt Hotel — Colonial Room

11:00 a.m. Business Meeting

2:00 p.m. Scientific Session
Demonstration: "The Preparation of Emulsified Extract," Ethan Allan Brown, Boston, Mass.

5:00 p.m. Cocktail Party, Skyroom, Independent Life Building

FLORIDA SOCIETY OF ANESTHESIOLOGISTS

George C. Austin, President ..... Miami
Richard S. Hodes, Pres.-Elect ..... Tampa
J. Thomas Atkins, Vice Pres. ..... Jacksonville
George H. Mix, Secy.-Treas. ..... Lakeland

Saturday, April 9
George Washington Hotel — Spanish Room

8:00 p.m. Board of Directors Meeting

Sunday, April 10
George Washington Hotel — Spanish Room

9:00 a.m. Business Meeting

FLORIDA CHAPTER, AMERICAN COLLEGE OF CHEST PHYSICIANS

M. Eugene Flipse, President ..... Miami
Ivan C. Schmidt, Pres.-Elect,
Vice Pres. ..... West Palm Beach
Charles F. Tate Jr., Secy.-Treas. ..... Miami
Harold W. Johnston,
Program Chairman ..... Orlando

Sunday, April 10
George Washington Hotel — Ballroom

8:30 a.m. Registration
Presiding: M. Eugene Flipse

9:00 a.m. "A Case of Paradoxical Embolization with Attempted Surgical Treatment," Charles W. Silverblatt, Fred Wasserman, and Mark W. Wolcott

9:15 a.m. "A New Method of Bronchial Stump Closure," Mark W. Wolcott

9:30 a.m. Symposium on Pulmonary Hypertension
Moderator: Elwyn Evans
Participants: Lamar Crevasse, Francisco A. Hernandez, Robert S. Litwak, and W. Jape Taylor

11:00 a.m. "Pulmonary Mycoses," John J. Procknow, Chicago, Assistant Professor of Medicine, School of Medicine, University of Chicago

12:00 Noon Luncheon and business meeting
Presiding: Ivan C. Schmidt

1:30 p.m. "Histoplasmosis in South Florida," Louis Bennett, Charles F. Tate Jr., and George L. Baum

1:45 p.m. "Carcinoma of the Lung — the Great Masquerader — Pitfall of Early Diagnosis," Jack Reiss

2:00 p.m. Symposium on Common Esophageal Disorders
Moderator: DeWitt C. Daughtry
Participants: George P. Daurelle, Allan A. Kaplan, and Edward R. Woodward

3:00 p.m. Adjournment

FLORIDA SOCIETY OF DERMATOLOGY

Bruce M. Esplin, President ..... Miami
Helen L. T. Dexter, Vice-Pres. ..... Clearwater
Jack H. Bowen, Secy.-Treas. ..... Jacksonville

Program and place of meeting to be announced.

FLORIDA ACADEMY OF GENERAL PRACTICE

Walter J. Glenn, President ..... Fort Lauderdale
Elmer B. Campbell Sr., Pres.-Elect St. Petersburg
George W. Karelas, Vice Pres. ..... Newberry
A. MacKenzie Manson, Secy.-Treas. Jacksonville
Leonard L. Weil
Program Chairman ..... Miami Beach

Sunday, April 10
Roosevelt Hotel — Florida Room

9:00 a.m. Board of Directors Meeting

2:00 p.m. Scientific Session
"Laboratory Procedure in Relation to the Management of Infections," E. L. Foltz, Philadelphia, Staff Member, Pepper Laboratory of Clinical Medicine, University of Pennsylvania School of Medicine

3:00 p.m. Business Session

FLORIDA HEALTH OFFICERS' SOCIETY

Chester L. Nayfield, President.....Winter Haven
J. Basil Hall, Vice Pres.....Tavares
Lorenzo L. Parks, Secy.-Treas.....Jacksonville

Sunday, April 10
George Washington Hotel — Flamingo Room

2:00 p.m. "Public Health Nursing Time Studies," Edward Byrne, M.D.
Discussion

2:20 p.m. "Tuberculin Testing Among School Children of Palm Beach County," C. L. Brumback, M.D.
Discussion

2:40 p.m. "Human Leptospirosis in Florida," J. F. Malloy, M.D.; Arthur L. Lewis, D.V.M., and James L. McQueen, D.V.M.
Discussion

3:00 p.m. "Epidemiological Atypical Infections, A Preliminary Report," E. C. Prather, M.D.
Discussion

3:20 p.m. "Experience with the State Board of Health and Seminole County—Mental Health Project," Wayne Yeager, M.D.
Discussion

3:40 p.m. "Study of Hypertensive Drugs in a Health Department Visitation Program," R. J. Jarrell, M.D.
Discussion

4:00 p.m. Business Session

FLORIDA ASSOCIATION OF INDUSTRIAL AND RAILWAY SURGEONS

Lloyd J. Netto, President.....West Palm Beach
Fred H. Albee, Pres.-Elect.....Daytona Beach
Henry J. Babers Jr., Vice Pres.....Gainesville
John H. Mitchell, Secy.-Treas.....Jacksonville

Sunday, April 10
Independent Life Bldg. — Auditorium

1:00 p.m. Business Meeting

2:00 p.m. "The Treatment of Common Foot Problems," Carlos Scuderi, Chicago, Associate Professor, University of Illinois College of Medicine
Guest of Industrial and Railway Surgeons

3:30 p.m. "Epiphyseal of Injuries in Children," Crawford J. Campbell, Albany, N. Y., Associate Professor, Albany Medical College
Guest of Orthopedic Society

Note: Scientific Session being held in conjunction with Florida Orthopedic Society.

FLORIDA SOCIETY OF INTERNAL MEDICINE

Lawrence E. Geeslin, President.....Jacksonville
William C. Blake, Pres.-Elect.....Tampa
Scheffel H. Wright, Vice Pres.....Miami
Charles K. Donegan, Secy.-Treas.....St. Petersburg

Sunday, April 10
George Washington Hotel — Banquet Hall

2:00 p.m. Business Session

3:30 p.m. "Labor's Concern with Medical Care and Medical Insurance," Mr. James Brindle, Director, Social Security Department, United Automobile Workers

4:30 p.m. Social Hour

FLORIDA NEUROSURGICAL SOCIETY

W. Tracy Haverfield, President.....Miami
Irwin Perlmutter, Pres.-Elect.....Coral Gables
Edward J. Sullivan Jr., Secy.-Treas.....Jacksonville
J. Cornall Howarth, Program Chairman.....Orlando

Sunday, April 10
Hotel Robert Meyer — English Room

10:00 a.m. "Lesions of the Cerebella Pontine Angle," Paul C. Bucy, Chicago, Professor of Surgery, Northwestern University Medical School
Business Meeting (time to be announced)

FLORIDA OBSTETRIC AND GYNECOLOGIC SOCIETY

Homer L. Pearson Jr., President.....Miami
T. Bert Fletcher Jr., Pres.-Elect.....Tallahassee
Sam W. Denham, Secy.-Treas.....Jacksonville

Sunday, April 10
Hotel Robert Meyer — Windsor North

8:00 a.m. Breakfast — Meeting of Executive Committee

9:00 a.m. Business meeting and Election of Officers

10:00 a.m. "Vaginal Approach for Radical Surgery for Carcinoma of the Cervix," Milton L. McCall, Professor and Chairman, Department of Obstetrics and Gynecology, University of Pittsburgh, Pittsburgh, Pa.

FLORIDA SOCIETY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY

G. Dekle Taylor, President.....Jacksonville
Kenneth S. Whitmer, Pres.-Elect.....Miami
William H. Anderson Jr., 1st Vice Pres.....Ocala
Marion W. Hester, 2nd Vice Pres.....Lakeland
Joseph W. Taylor Jr., Secy.-Treas.....Jacksonville

Sunday, April 10
Mayflower Hotel
East and West Ballrooms

9:00 a.m. President's Welcoming Address (Joint)

9:05 a.m. "The Voice of the Porpoise — Seeing With Sound When Submerged," Mr. F. G. Wood, Curator, Marineland Research Laboratory (Joint)

OPHTHALMOLOGISTS' SCIENTIFIC SESSION
East Ballroom

9:30 a.m. "Some Physiological Considerations of Hereditary Macular Degenerations," Rodney D. Steinmetz, Tampa
Discussion

9:50 a.m. "Ophthalmodynamomentry in the Diagnosis of Carotid Artery Disease," Thomas G. Dickinson, Sarasota
Discussion

10:10 a.m. (Title to be announced) W. Jerome Knauer Jr., Jacksonville
Discussion

10:30 a.m. "Congenital Lesions of the Retina," Melvin White, Capt. (MC) USAF MacDill Air Force Base, Tampa
Discussion

10:50 a.m. "An Ophthalmologic Approach to the Problem of the Retarded Reader Among Children in Elementary Schools," Curtis D. Benton Jr., Fort Lauderdale
Discussion

11:10 a.m. "Case Report: Spastic Ectropion," William H. Anderson Jr., Ocala

11:30 a.m. Mr. Lee A. Iverson, St. Augustine, Florida School for the Deaf and Blind

11:45 a.m. General Discussion

East and West Ballrooms

12:00 Luncheon—Business Meeting and Election of Officers (Joint)

East Ballroom

2:00 p.m. "Pointers From Keratoplasty," H. Carlton Howard, Miami

Discussion

2:20 p.m. Mr. George Emmanuele, Tampa. Annual Report of Florida Council for Blind.

East and West Ballrooms

6:30 p.m. Cocktail Hour (Joint)

OTOLARYNGOLOGISTS' SCIENTIFIC SESSION

West Ballroom

9:30 a.m. "Glomus Jugulare Tumors — Diagnosis and Management," G. Dekle Taylor, Jacksonville

Discussion

9:50 a.m. "Laryngeal Manifestations of Allergy," Bernard M. Barrett, Pensacola

Discussion

10:10 a.m. "Hearing Loss Secondary to Whiplash Injuries," Warren C. Evans, Sarasota

Discussion

10:30 a.m. "Case Report — Rhabdomyosarcoma of the Nasopharynx in a Three Year Old Child," Millard F. Jones, Jacksonville

Discussion

10:50 a.m. "Cholesteatoma of the Middle Ear," John H. Webb Jr., Orlando

Discussion

11:10 a.m."Malignancy of the Larynx as Managed in a Smaller Community Hospital," Eric H. Lenholt, Daytona Beach

Discussion

11:30 a.m. "Canaloplasty for Acquired Stenosis of the External Auditory Canal," J. Brown Farrior, Tampa

Discussion

11:50 a.m. General Discussion

East and West Ballrooms

12:00 Luncheon — Business Meeting and Election of Officers (Joint)

West Ballroom

2:00 p.m. "Your School for the Deaf," Richard K. Lané, M.A., Principal, Department for the Deaf, Florida School for the Deaf and Blind, St. Augustine

Discussion

2:20 p.m. "The Nose in Pregnancy," Manuel A. Schofman, Miami

Discussion

2:40 p.m. "The Management of Secretory Otitis Media," Charles Pinkoson, Gainesville

Discussion

East and West Ballrooms

6:30 p.m. Cocktail Hour (Joint)

FLORIDA ORTHOPEDIC SOCIETY

Elwin G. Neal, President ..... Miami Shores
Michael A. DiCosola, Vice Pres. ..... Sarasota
Richard A. Worsham, Secy.-Treas. ..... Jacksonville
John F. Lovejoy,
Program Chairman ..... Jacksonville

Sunday, April 10

Independent Life Bldg. — Auditorium

2:00 p.m. "The Treatment of Common Foot Problems," Carlos Scuderi, Chicago
Guest of Industrial and Railway Surgeons

3:30 p.m. "Epiphyseal of Injuries in Children," Crawford J. Campbell, Albany, N. Y., Associate Professor, Albany Medical College
Guest of Orthopedic Society

4:45 p.m. Business Meeting, French Room Hotel Robert Meyer

6:00 p.m. Social Hour (Place to be announced)

Note: Scientific Session being held in conjunction with Florida Association of Industrial and Railway Surgeons

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FLORIDA SOCIETY OF PATHOLOGISTS

James B. Leonard, President ..... Clearwater
John B. Miale, Vice Pres. ..... Miami
W. Ansell Derrick, Treasurer ..... Orlando
John A. Shively, Secretary ..... Bradenton
Sanford A. Mullen,
Program Chairman ..... Jacksonville

Sunday, April 10

George Washington Hotel — Blue Room

1:00 p.m.
to
5:00 p.m. "Recent Developments in Microbiology." Participation by faculty members of College of Medicine, University of Florida, University of Miami School of Medicine, and members of Florida Society of Pathologists

FLORIDA PEDIATRIC SOCIETY

Harry M. Edwards, President ..... Ocala
J. K. David Jr., Pres.-Elect ..... Jacksonville
John H. Cordes Jr., Secretary ..... St. Petersburg
Fred I. Dorman Jr., Treasurer ..... Lakeland

Sunday, April 10
Roosevelt Hotel—Mayport Room

10:00 a.m. "Therapy of First Attacks of Acute Rheumatic Fever," Andrew E. Lorincz, Assistant Professor, Department of Pediatrics, College of Medicine, University of Florida.

10:25 a.m. "Recent Experience with Endocardiac Surgery," Myron W. Wheat Jr., Assistant Professor, Department of Surgery, and Chief, Cardiovascular Division, College of Medicine, University of Florida

10:50 a.m. Coffee Break

11:00 a.m. "Unusual Problems in Infectious Diseases Management," Richard T. Smith, Professor and Chairman, Department of Pediatrics, College of Medicine, University of Florida

11:25 a.m. "Diagnostic Problems in C.N.S. Neoplasm in Childhood," Allen N. Jelks, Instructor, Department of Pediatrics, College of Medicine, University of Florida

2:00 p.m. "New Concepts in Hare Lip and Cleft Palate Management," Maurice J. Jurkiewicz, Assistant Professor, Department of Surgery, and Chief, Division of Plastic Surgery, College of Medicine, University of Florida

2:25 p.m. "Emergency Management of Fractures in Children," William F. Enneking, Associate Professor, Department of Surgery, and Chief, Division of Orthopedics, College of Medicine, University of Florida

2:50 p.m. Coffee Break

3:00 p.m. Panel Discussion: Drs. Wheat, Smith, Jelks, Jurkiewicz and Enneking

4:00 p.m. Business Meeting

6:30 p.m. Cocktail Party

FLORIDA SOCIETY OF PLASTIC AND RECONSTRUCTIVE SURGERY

Clifford C. Snyder, President ..... Miami
Joseph E. O'Malley, Vice Pres. ..... Orlando
Bernard L. N. Morgan, Secy.-Treas. Jacksonville

Sunday, April 10
Hotel Robert Meyer — French Room

9:30 a.m. Business Meeting and Election of Officers

11:00 a.m. Scientific Session
Dr. John M. Converse, New York, Lawrence D. Bell Professor of Plastic Surgery, New York University College of Medicine. (Title to be announced)

Technical Exhibits
Hotel Robert Meyer
Open 8:30 a.m. to 5:30 p.m.

FLORIDA PROCTOLOGIC SOCIETY

Don C. Robertson, President ..... Orlando
Matthew A. Larkin, Secy.-Treas. ..... Miami

Sunday, April 10
Hotel Robert Meyer — Spanish Room

10:30 a.m. Scientific Session
Symposium on Ulcerative Colitis
Moderator: Patrick H. Hanley, Ochsner Clinic, New Orleans
Participants: Donald F. Marion, Miami; Paul J. Fuzy, Fort Lauderdale; James A. Whiteside, Coral Gables, and Matthew A. Larkin, Miami

10:45 a.m. "Ulcerative Colitis from a Gastroenterologic View," Dr. Marion

11:05 a.m. "Anorectal Manifestations and Management," Dr. Fuzy

11:25 a.m. "Ulcerative Colitis in Children," Dr. Whiteside

11:45 a.m. "Surgical Treatment of the Complications of Ulcerative Colitis," Dr. Larkin

12:05-12:35 Discussion

1:00 p.m. Luncheon

2:30 p.m. Business Meeting; Election of Officers

6:30 p.m. Cocktail Party and Dinner

FLORIDA PSYCHIATRIC SOCIETY

Samuel R. Warson, President ..... Sarasota
Samuel G. Hibbs, Pres.-Elect ..... Tampa
Merton L. Ekwall, Secretary ..... Jacksonville
Bernard Goodman, Treasurer ..... Miami Beach
Walter H. Wellborn Jr.,
Program Chairman ..... Tarpon Springs

Sunday, April 10
Roosevelt Hotel — Tropical Room

9:00 a.m. Business Session

11:00 a.m. "Folklore, Mushrooms and Experimental Psychiatry," Howard P. Rome, Mayo Clinic, Rochester, Minn.

7:00 p.m. Cocktail Party and Dinner — The Chateau, Atlantic Beach
Note: There is no scheduled afternoon program. Society members may desire to attend the meetings of other specialty groups.

FLORIDA RADIOLOGICAL SOCIETY

Russell D. D. Hoover
President ..... West Palm Beach
John S. Stewart, Pres.-Elect ..... Fort Myers
Alfred G. Levin, Vice Pres. ..... Miami
John P. Ferrell, Secretary ..... St. Petersburg
Ivan Isaacs, Treasurer ..... Jacksonville

Sunday, April 10
Mayflower Hotel—Pilgrim and Plymouth Rooms

9:30 a.m. Business Meeting

1:30 p.m. Scientific Session
Members of the Society are requested to bring their interesting films for presentation. All members of Florida Medical Association are invited to bring films for discussion and diagnosis.

6:30 p.m. Cocktail Party—Beauclerc Country Club

7:30 p.m. Banquet—Beauclerc Country Club

FLORIDA CHAPTER, AMERICAN COLLEGE OF SURGEONS

George W. Morse, President ..... Pensacola
Donald W. Smith, Pres.-Elect ..... Miami
Francis H. Langley, Vice Pres. ..... St. Petersburg
C. Frank Chunn, Secy.-Treas. ..... Tampa
Frederick H. Bowen,
Program Chairman ..... Jacksonville

Sunday, April 10
Mayflower Hotel — Skyroom

10:00 a.m. Scientific Session
"Burns," John L. Bell, Chicago, Assistant Professor of Surgery, Northwestern University Medical School

"Popliteal Aneurysm — An Urgent Vascular Problem," James D. Moody, Orlando

Business Meeting

6:00 p.m. Cocktail Party

NOTE: Rooms have been assigned to the various specialty groups. The Florida Medical Association is not to furnish projecting lanterns or any of the equipment necessary for the holding of such meetings.

FLORIDA ASSOCIATION OF GENERAL SURGEONS

C. Burling Roesch, President ..... Jacksonville
Richard M. Fleming, Pres.-Elect ..... Miami
Thad Moseley, Secy.-Treas. ..... Jacksonville

Sunday, April 10
Mayflower Hotel — Puritan Room

8:00 p.m. Amos R. Koontz, Baltimore

9:00 p.m. Business Session—Election of Officers

FLORIDA UROLOGICAL SOCIETY

Edwin W. Brown, President ..... West Palm Beach
H. Lawrence Smith, Pres.-Elect ..... Tallahassee
William A. Van Nortwick,
Secy.-Treas. ..... Jacksonville

Sunday, April 10
George Washington Hotel — East Room

2:00 p.m. Business Session

3:00 p.m. Scientific Session
Program to be announced

6:00 p.m. Cocktail Party

Headquarters Hotels

Robert Meyer

George Washington

Scientific Assemblies

Monday, April 11
Hotel Robert Meyer—Windsor North

THIRD SCIENTIFIC ASSEMBLY

Presiding: Franz H. Stewart, M.D.

9:15 a.m. **"Management of Acute Trauma of the Hand"**

John L. Bell, M.D., Chicago, Assistant Professor of Surgery, Northwestern University Medical School.

9:35 a.m. **"The Treatment of Craniocerebral Injuries"**

Paul C. Bucy, M.D., Chicago, Professor of Surgery, Northwestern University Medical School.

9:55 a.m. **"Problems Peculiar to the Management of Acute Traumata in the Bones of Children"**

Crawford J. Campbell, M.D., Albany, N. Y., Associate Professor at Albany Medical College.

10:15 a.m. **"Blow-Out Fracture of the Floor of the Orbit"**

John M. Converse, M.D., New York, Lawrence D. Bell, Professor of Plastic Surgery, New York University College of Medicine.

Presiding: Charles K. Donegan, M.D.

11:00-12:00 Panel: **"Management of Acute Trauma"**

Moderator: John J. Farrell, M.D.

Panel Members: Drs. Bell, Bucy, Campbell and Converse

Second Meeting
House of Delegates

Monday, April 11
Hotel Robert Meyer—Windsor North

Delegates sign official attendance cards at 1:30 p.m. at the table of the Credentials Committee, Franklin J. Evans, Chairman, Rowland E. Wood, and Egbert V. Anderson, located at entrance to Windsor Room North. No alternates are to be seated for Delegates attending Friday's meeting.

2:00 p.m. President Jack in the Chair.

Number of eligible Delegates present, report by Franklin J. Evans

Presentation of Life Certificates

Recommendations of Reference Committees:

No. 1 Health and Education
Robert L. Tolle, Chairman

No. 2 Public Policy
Edward R. Annis, Chairman

No. 3 Finance and Administration
Edward Jelks, Chairman

No. 4 Legislation and Miscellaneous
Edward W. Cullipher, Chairman

Other unfinished business

Election of Association Officers

President-Elect

Vice President

Speaker of the House

Vice Speaker of the House (Optional)

Secretary-Treasurer

Committee on Membership and Discipline (16 members—2 from each Congressional District) See Board of Governors Report, Handbook, for list of nominees.

Dr. Leo M. Wachtel escorted to the Chair as new President

Presentation of Personal Gavel to Dr. Wachtel

Presentation of Past President's Button and Certificate of Honor to Dr. Ralph W. Jack by Dr. Leo M. Wachtel, President

Benediction, Homer L. Pearson Jr.

Adjournment

Technical Exhibits

The Technical Exhibits are located in Windsor South and on the Mezzanine of the Hotel Robert Meyer. They have a definite scientific value, and physicians who wish to keep abreast of the times and be familiar with the latest development in drugs and medical appliances should spend some time with these exhibits; a surprising amount of useful information can be procured in this way.

Many exhibitors make no attempt to sell, the representatives of the firms being there primarily to give the latest information regarding their products. Those who have items for sale will gladly give information whether there is a purchase or not. Be sure to register your name with the various representatives who are exhibiting.

Exhibitor	Booth Number
Abbott Laboratories	25
A. S. Aloe Company	53
American Ferment Co., Inc.	22
Anderson Surgical Supply Co.	4
Audio-Digest Foundation	14
Borcherdt Company	1
The Borden Company	12
Brayten Pharmaceutical Co.	67
Burroughs Wellcome and Co.	42
Carnation Company	24
Chicago Pharmacal Co.	28
Ciba Pharmaceutical Products, Inc.	59
The Coca-Cola Co.	70
Coreco Research Corp.	41
Desitin Chemical Co.	63
Dictaphone Corp.	8
The Doho Chemical Corp.	34
Drug Specialties, Inc.	40
Eaton Laboratories	64
Eisele and Company	23
Enfield's	11
H. G. Fischer & Co.	37
Florida Brace Corp.	48
Geigy Pharmaceuticals	16
Great Books of the Western World	32
Charles C. Haskell & Co.	35
Hoffmann-LaRoche, Inc.	66
Keleket X-Ray of Florida	13
Kremers-Urban Company	71
Eli Lilly and Co.	36
Lloyd Brothers, Inc.	15
J. A. Majors Co.	29
Maltbie Laboratories	3
S. E. Massengill & Co.	18
Mead Johnson and Company	50
The Medical Protective Co.	33
Medical Supply Co.	26
Medical Supply Co. of Jacksonville	43
Merck Sharp and Dohme, Inc.	2
The Wm. S. Merrell Co.	39
C. V. Mosby Company	60
V. Mueller & Co.	27
The National Drug Co.	19
Organon, Inc.	68
Ortho Pharmaceutical Corp.	55
Parke, Davis and Co.	49
Pet Milk Company	58
Pfizer Laboratories	61
R. J. Reynolds Tobacco Co.	73
Riker Laboratories	20
A. H. Robins Co., Inc.	52
J. B. Roerig and Co.	30
Ross Laboratories	10
Sanborn Company	7
Sandoz Pharmaceuticals	47
Schering Corp.	57
Julius Schmid, Inc.	65
G. D. Searle and Co.	72
Sherman Laboratories	9
E. R. Squibb and Sons	51
Surgical Equipment Co.	38
Surgical Supply Co.	17
Swift & Company	45
S. J. Tutag & Co.	6
The Upjohn Co.	46
VanPelt & Brown, Inc.	31
Walker Laboratories	69
Wampole Laboratories	5
Warner-Chilcott Laboratories	56
Westinghouse Electric Corp.	44
Westwood Pharmaceuticals	62
White Laboratories, Inc.	54
Winthrop Laboratories	21

Scientific Exhibits

Hotel George Washington — Auditorium

Booth No.	
2	"Bureau of Professional Relations, College of Pharmacy, University of Florida," Mr. Charles S. Haupt, Gainesville
3	"Florida Association of Blood Banks," Miss Minnie Schreiber, Jacksonville
4	"Blue Shield of Florida, Inc.," Russell B. Carson, M.D., President
5	"Insurance Program—Florida Medical Association," Mr. Leyton B. Hunter, Atlanta
6-7	"Standard Nomenclature," American Medical Association, Chicago
8-9-22	"Cerebral Apoplexy: Types, Causes and Pathogenesis," Philip Schwartz, M.D., Warren, Pa.
10-11	"Ear Surgery in 3-D," J. Brown Farrior, M.D., Tampa
12	"Growth Failure—A Sign of Many Diseases of Childhood," Richard T. Smith, M.D., Gainesville
13	"Carotid Artery Insufficiency: Early Diagnosis and Treatment," Lamar Crevasse, M.D., Richard P. Schmidt, M.D., and Myron W. Wheat, M.D., Gainesville
14	"Cryoglobulinemia and Macroglobulinemia," Ulfar Jonsson, M.D., and Howard E. Lessner, M.D., Miami
15	"Acceptable Operations on the Biliary Tract," Harry W. Reinstine Jr., M.D., and Emmet F. Ferguson Jr., M.D., Jacksonville
16	"The Electronic Control of Mechanical Devices Through Physiological Mechanisms," Sam E. Stephenson, M.D., Nashville, Tenn.
17-18-19	"Treatment of Cancer by Perfusion," Oscar Creech Jr., M.D., E. T. Krementz, M.D., R. F. Ryan, M.D. Keith Reemtsma, M.D., J. N. Winblad, M.D., and James L. Elliott, M.D., New Orleans
20-21	"Facial Pain," Arnold P. Friedman, M.D., New York
23	"Woman's Auxiliary to the Florida Medical Association," Mrs. Wendell J. Newcomb, President
24	"Progressive Muscular Dystrophy," Miss Elizabeth E. Walldov, New York
25-26	"Cystic Fibrosis of the Pancreas," Stephen P. Gyland Jr., Jacksonville
28	"Jacksonville Hospitals Educational Program," Max Michael Jr., M.D., Jacksonville
29	"Obstetric Obesity," Richard X. Sands, M.D., New York

30-31 "Oncology of the Head and Neck; Primary and Reconstructive Surgery," Richard T. Farrior, M.D., and Garland S. Dummit, M.D., Tampa

32 "Sunland Training Center," Charles H. Carter, M.D., Gainesville

33-34 "Emergency Hospital Exhibit and Accident Prevention," Civil Defense and Florida State Board of Health, Lorenzo L. Parks, M.D., Jacksonville

36 "Florida Medical Foundation," John D. Milton, M.D., President

37-38 "Where There Is Smoke," Mr. John Carbonneau, Florida Division, American Cancer Society, Tampa

Physician's Hobbies

Hotel George Washington — Auditorium

1 Jazz, Samuel S. Lombardo, M.D., Jacksonville

43 Wood Carving, Collins W. Swords Jr., M.D., Miami

41 Painting, Floyd K. Hurt, M.D., and Charles B. Mabry, M.D., Jacksonville

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PROGRAM
THIRTY-THIRD ANNUAL MEETING
WOMAN'S AUXILIARY TO THE FLORIDA MEDICAL ASSOCIATION

HOSTESS AUXILIARY: Woman's Auxiliary to the Duval County Medical Society

Convention Chairman ..... Mrs. J. K. David, Jr.
Co-chairman ..... Mrs. Willard R. Gatling

CONVENTION COMMITTEE CHAIRMEN

House of Delegates Meeting ..... Mrs. S. James Beale
Credentials and Registration ..... Mrs. Sidney Halpern
Luncheon Chairman ..... Mrs. Wilbur C. Sumner
Mrs. Lucien Y. Dyrenforth
Mrs. A. Judson Graves
Mrs. Joseph A. J. Farrington
Board Meeting Arrangements Chairmen
Pre-Convention ..... Mrs. Samuel S. Lombardo
Post-Convention ..... Mrs. Joel Fleet
Buffet and Dance ..... Mrs. John F. Lovejoy
Publicity Chairman ..... Mrs. Wade S. Rizk
Mrs. A. Sherrod Morrow
Hospitality Chairman ..... Mrs. Stephen P. Gyland Jr.
Golf Tournament Chairman ..... Mrs. William H. McCullagh
Finance Chairman ..... Mrs. Charles F. McCrory
Decorations Chairman ..... Mrs. William H. Mathews
Exhibits Chairman ..... Mrs. Irvine K. Furman

AD HOC COMMITTEE CHAIRMEN

Courtesy Resolutions Committee ..... Mrs. James B. Glanton
Election Committee ..... Mrs. James F. Cooney
Reading Committee ..... Mrs. Clarence W. Ketchum
Timekeepers Committee Mrs. Russell B. Carson
Observer Corps ..... Mrs. Joseph C. Von Thron

GENERAL INFORMATION

GENERAL REGISTRATION will be held in the Windsor South at the Hotel Robert Meyer Friday, Saturday and Sunday, 8:30 a.m. to 5:30 p.m., and Monday, 8:30 a.m. to 4:00 p.m.

REGISTRATION FOR DELEGATES to the Auxiliary House of Delegates will be held in the Ball Room, Hotel George Washington, Saturday, April 9, 8:30 a.m. to 9:30 a.m.

AUXILIARY MEETINGS will be held at various locations. Please see program for time and place.

DAILY SCHEDULE

FRIDAY, April 8 — Sky Room
Independent Life Insurance Building

1:30 p.m. Pre-Convention Board of Directors Meeting—Mrs. Wendell J. Newcomb, Presiding

4:00 p.m. State Membership Committee Meeting Mrs. John M. Butcher, Presiding. (Suite of President and President-Elect in Hotel George Washington.)

SATURDAY, April 9
Ball Room — Hotel George Washington

9:30 a.m. ANNUAL MEETING OF THE HOUSE OF DELEGATES, WOMAN'S AUXILIARY TO THE FLORIDA MEDICAL ASSOCIATION. ALL AUXILIARY MEMBERS ARE INVITED TO ATTEND.

1:00 p.m. ANNUAL LUNCHEON — Rainbow Room — Hotel George Washington
Address: Dr. Darrel J. Mase, Dean, College of Health Related Services, University of Florida

4:00 p.m. Interview Hour in suite of Auxiliary President and President-Elect in Hotel George Washington

6:30-7:30 p.m. Florida Medical Association President's Reception, Skyroom, Mayflower Hotel

8:00 p.m. Buffet dinner and dance—East and West Ballrooms, Mayflower Hotel

Sunday, April 10

12:30 p.m. Post convention board meeting
Flamingo Room—Hotel George Washington
Presiding: Mrs. John M. Butcher
Speakers: Leo M. Watchel, M.D., President-Elect, Florida Medical Association and Samuel M. Day, M.D., Secretary-Treasurer, Florida Medical Association.

Meeting will recess immediately following Dr. Day's message and reconvene aboard the Yacht Kay-Bob where a Dutch Treat Luncheon will be served at $4.00 per person. (Scarf for head and low heel shoes recommended).

PROGRAM FOR THE ANNUAL MEETING HOUSE OF DELEGATES

Ball Room — Hotel George Washington Saturday, April 9—9:30 a.m.

CALL TO ORDER: Mrs. Wendell J. Newcomb, President

INVOCATION: Mrs. Sidney G. Kennedy, Jr.

PLEDGE OF LOYALTY: *I pledge my loyalty and devotion to the Woman's Auxiliary to the Florida Medical Association. I will support its activities, protect its reputation and ever sustain its high ideals.* Led by Mrs. John D. Browning.

ADDRESS OF WELCOME: Mrs. Edward W. Ludwig, President, Woman's Auxiliary to the Duval County Medical Society.

RESPONSE TO THE WELCOME ADDRESS: Mrs. R. Spencer Howell

INTRODUCTIONS: Mrs. Wendell J. Newcomb

REMARKS FROM THE PRESIDENT, FLORIDA MEDICAL ASSOCIATION: Dr. Ralph W. Jack

REMARKS FROM THE CHAIRMAN OF THE ADVISORY BOARD: Dr. Sidney G. Kennedy, Jr.

MEMORIAL SERVICE: Mrs. Michael A. DiCosola

BUSINESS SESSION:

CONVENTION RULES OF ORDER: Mrs. Clyde E. Miller, Jr., Parliamentarian
ROLL CALL OF VOTING DELEGATES: Mrs. Max Suter, Recording Secretary
MINUTES OF THE THIRTY-SECOND ANNUAL MEETING: Mrs. Suter
REPORT OF REGISTRATION: Mrs. Sidney Halpern

REPORTS OF STATE OFFICERS AND COMMITTEE CHAIRMEN:

NOTE — If there is no objection, the reports of state officers and chairmen will be accepted as printed and placed on file, except for such reports that require action by the body of the convention and those which must be presented orally, as required by our By-Laws. Those reports that must be given orally, according to the By-Laws are those of the TREASURER, the FINANCE CHAIRMAN, the FLORIDA AUXILIARY MEDICAL EDUCATION FUND CHAIRMAN, and the REVISIONS AND RESOLUTIONS CHAIRMAN.

INTRODUCTION OF PRESIDENTS OF NEW COMPONENT AUXILIARIES

REPORTS OF PRESIDENTS OF COMPONENT AUXILIARIES:

Alachua: Mrs. Raymond J. Fitzpatrick
Bay: Mrs. Charles H. Daffin
Brevard: Mrs. Joseph C. Von Thron
Broward: Mrs. Russell B. Carson
Dade: Mrs. R. Spencer Howell
Duval: Mrs. Edward W. Ludwig
Escambia: Mrs. P. G. Batson, Jr.
Highlands: Mrs. Hubert W. Coleman
Hillsborough: Mrs. J. M. Ingram, Jr.
Jackson-Calhoun: Mrs. Courtland D. Whitaker
Lake-Sumter: Mrs. Thomas D. Weaver
Lee-Hendry: Mrs. H. Quillian Jones
Leon-Gadsden-Liberty-Wakulla - Jefferson: Mrs. Clarence W. Ketchum
Manatee: Mrs. Alva J. Floyd
Marion: Mrs. Earl E. Yantis
Orange: Mrs. James B. Glanton
Palm Beach: Mrs. James F. Cooney
Pinellas: Mrs. John P. Rowell
Polk: Mrs. Harry E. Halden III
Putnam: Mrs. Benjamin J. Massey
St. Johns: Mrs. Joseph A. Shelley
St. Lucie-Okeechobee-Martin: Mrs. John D. Browning
Sarasota: Mrs. Michael A. DiCosola
Seminole: Mrs. William V. Roberts
Volusia: Mrs. Carroll M. Crouch

UNFINISHED BUSINESS

NEW BUSINESS

REPORT OF THE COURTESY RESOLUTIONS COMMITTEE: Mrs. James B. Glanton

ELECTION OF 1961 NOMINATING COMMITTEE

ELECTION OF DELEGATES TO THE NATIONAL CONVENTION

REPORT OF THE 1960 NOMINATING COMMITTEE: Mrs. Lee Rogers, Jr., Chairman

ELECTION OF 1960-1961 AUXILIARY OFFICERS

INSTALLATION OF OFFICERS: Mrs. J. M. Chenault, President, Woman's Auxiliary to the Southern Medical Association

PRESENTATION OF THE GAVEL AND PRESIDENT'S PIN: To the new president by Mrs. Newcomb

PRESENTATION OF THE PAST PRESIDENT'S PIN: To Mrs. Newcomb by Mrs. Rogers

INAUGURAL MESSAGE: Mrs. John M. Butcher

ADJOURNMENT

Technical Exhibit

A feature that adds materially to the success of the Annual Meeting is the technical exhibits. Each firm represented features products of particular interest to the physician. Make a special effort to visit each booth at some time during the meeting and register your name with the attending representative.

The Technical Exhibit will be open Friday, Saturday and Sunday, 8:30 a.m. to 5:30 p.m., and on Monday from 8:30 a.m. to 4:00 p.m. The booths may be dismantled after 4:00 p.m.

ABBOTT LABORATORIES 25
North Chicago, Ill.
The Abbott Laboratories exhibit will feature the antibiotic triad — three products which together provide control of all coccal infections: Erythrocin Stearate for control of staph-, strep- and pneumococci; Compocillin-VK against penicillin-sensitive organisms; and Spontin for the serious coccal infections that hospitalize the patient. Also exhibited will be two products now available in Abbott's unique new "metered release" dose form — Tral Gradumets and Desoxyn Gradumets, plus a selection of other Abbott specialites.

AUDIO-DIGEST FOUNDATION 14
Glendale, Calif.
Audio-Digest Foundation (a non-profit subsidiary of the California Medical Association), gives the busy physician a time-saving tour through the best of some 600 current medical journals, plus the highlights of scores of national meetings. Time-proven, but still unique, these medical, tape-recorded services are now offered in six series — General Practice (issued weekly and bi-weekly), and Pediatrics, Internal Medicine, Surgery, Obstetrics and Gynecology, Anesthesiology (all issued semi-monthly). The one-hour long tapes are selected and reviewed by a professional Board of Editors. Digest subscribers listen in their car, home or office. The Foundation also offers medical lectures by nationally-recognized authorities.

BORCHERDT CO. 1
Chicago, Ill.
Two time-tested products are being shown at this meeting: Malt soup extract for constipation and intractable pruritus ani. This dietary product acts on the intestinal flora to produce a predominantly aciduric flora. Urolitia is a mild soothing urinary antiseptic for geriatric patients.

Register for samples and information on these products.

THE BORDEN CO. 12
New York, N. Y.
First among the many new items on display at the Borden Pharmaceutical Division booth this year is Liquid Bremil. Introduced only a few months ago, Liquid Bremil adds the convenience of a liquid to the significant advantages established by Bremil Powdered. Borden representatives will be happy to tell you about the latest improvements in Mull-Soy, the original hypoallergenic formula. New additions to the Borden line in the field of skin care are Dermabase, an all purpose ointment base, and Junitar, the nonstaining tar bath, as well as Marcelle hypoallergenic cosmetics, safe beauty aids for teenagers and grownups with sensitive skins.

BRAYTEN PHARMACEUTICAL CO. 67
Chattanooga, Tenn.
Mr. Don Benoway will be in charge of the Brayten exhibit. He will present Brayten products of current interest— briefly and thoroughly.

CARNATION CO. 24
Los Angeles, Calif.
Carnation Company cordially invites you to visit Booth 24, where Medical Specialist representatives will be pleased to welcome old and new friends.

Recent literature and information regarding Carnation Evaporated, Carnation Instant Non-Fat and our newest product Carnalac are available.

Any question pertaining to our physician-researched material for use in your practice or hospital will be cheerfully discussed.

CHICAGO PHARMACAL CO. 28
Chicago, Ill.
Prenaphos: The most modern, complete and effective prenatal formula on the market today.

Urised: Nationally known and clinically proven tablet for both comfortable sedation and thorough antisepsis in all types of genito-urinary affections.

Juniplex: An excellent tasting liquid tonic for both children and adults which contains all the essential minerals as well as the entire B complex plus 30 micrograms of B12 per teaspoonful.

Estrosed: A pleasant tasting, economical tablet combining the safest of the tranquilizers, Reserpine, and the most potent of the oral estrogens, Ethinyl Estradiol, for the safe and effective treatment of the menopausal syndrome.

THE COCA-COLA CO. 70
Atlanta, Ga.
Ice-cold Coca-Cola served through the courtesy and cooperation of the Jacksonville Coca-Cola Bottling Company and The Coca-Cola Company.

CORECO RESEARCH CORP. 41
New York, N. Y.
The Coret Camera embodies the principle of electronic flash and constant automatic control of such factors as distance, aperture, field and exposure. Now, for the first time, Coreco offers a completely automatic professional clinical camera purposely designed to achieve the ultimate in surface, intra-oral and intra-tubular photography. Because of the simplicity of operation, even an inexperienced doctor or nurse can achieve consistently perfect color transparencies.

DESITIN CHEMICAL CO. 63
Providence, R. I.
Desitin Ointment: For treatment of burns, ulcers, diaper rash, abrasions, etc.; Desitin Powder; Relieves chafing, sunburn, diaper rash, etc.; Desitin Suppositories and Rectal Ointment: Relieve pain and itching in uncomplicated hemorrhoids, fissures; Desitin Baby Lotion; Protective, antiseptic; Desitin Acne Cream: A nonstaining, flesh-tinted "Medicream" for treatment of Acne Vulgaris; Desitin Cosmetic and Nursery Soap; Supermild; Desitin Suppositories with Hydrocortisone; Prompt response to inflammatory conditions in proctitis, severe pruritus, edema.

DICTAPHONE CORP. 8
New York, N. Y.
Busy doctors use the latest and best means of communication—the Dictaphone Time-Master dictating machine and the Dictabelt record. For just pennies a day, doctors have discovered a wonderfully efficient and

effortless way to reduce the strain of too much paperwork. Result: they can devote more time to the most rewarding job—helping their patients.
With a Time-Master on your desk it's said and done in half the time and at less cost. No doctor can afford to settle for less than the best in communication. Very few do.

DOHO CHEMICAL CORP. 34
New York, N. Y.
Doho Chemical Corporation is pleased to exhibit:
Auralgan: Otitis Media and removal of Cerumen; Otosmosan: Fungicidal and Bactericidal in the suppurative and aural dermatomycotic ears; Rhinalgan: Nasal decongestant free from systemic or circulatory effect; Larylgan: Throat spray and gargle for infectious and non-infectious sore throat involvements.
Mallon Chemical Corporation, Division of Doho:
Rectalgan: For relief of pain and discomfiture in hemorrhoids, pruritus and perineal suturing; Dermoplast: An Aerosol Spray for surface pain, burns and abrasions; Obs. & Gyn. use.

DRUG SPECIALTIES, INC. 40
Winston-Salem, N. C.
Drug Specialties, Inc. will be featuring at booth #40: Nicozol, the original cerebral stimulant and tonic for the aged; Nicozol Complex, a modern restorative tonic; and 1-Iron, an improved hematinic, featuring maximum absorption without GI irritation . . . a one capsule daily iron preparation for all treatable iron deficiency anemias.

EATON LABORATORIES 64
Norwich, N. Y.
Altafur®.M. (brand of furaltadone), the first nitrofuran effective orally in systemic bacterial infections. High clinical efficacy in pneumonias, bronchiolitis, bronchitis, tonsillitis and otitis media; also in soft tissue infections, cellulitis and abscess, surgical wound infections and infected lacerations.

ENFIELD'S 11
Miami, Fla.
Florida physicians are taking advantage of the "Thermo-Fax" all electric copying process more than ever before.
You are cordially invited to see how you too can prepare up to 1000 itemized patient statements in a single morning. The key to this Instant Electric Billing is the "Thermo-Fax" Copying Machine. It will not only assist you in obtaining your Collections Faster but will provide your office with More Time for other duties and offers a Better Service to patients by giving them the complete picture of their account. Other important papers, too, letters, accident reports, insurance claims and even electrocardiograms can be copied—in just four seconds.
All this office efficiency can be yours for less than the cost of many typewriters. Why not see a fast four second demonstration of this new "Thermo-Fax" billing system at our exhibit booth today?

EISELE & CO. 23
Nashville, Tenn.
Eisele & Company will display their regular line of clinical thermometers, hypodermic syringes, both the regular type and the interchangeables; Hypodermic needles, Eco bandages and specialty glassware.

GEIGY PHARMACEUTICALS 16
Yonkers, N. Y.
Geigy Pharmaceuticals cordially invites members and guests of the Association to visit its technical display. Tofranil,® a new agent, specifically for depression, will be featured. Information on other products valuable in the therapy of rheumatic, metabolic, dermatologic and cardio-vascular diseases will be presented by personnel in attendance.

GREAT BOOKS OF THE WESTERN WORLD 32
Grand Rapids, Mich.
The Great Ideas Program, a new advancement in liberal education, is built around the revolutionary Syntopicon. This master-key "Idea-Indexes" all the Great Books, making it possible to find what the great writers and thinkers said about *any* ideas in minutes. The Program will help business and professional people, students, graduates — or anyone interested in exploring the fascinating world of great ideas.

CHARLES C. HASKELL & CO. 35
Richmond, Va.
The Haskell representatives will be happy to discuss new developments in connection with the familiar Belbarb, Hasamal, Hasacode products. In addition will be featured Dipralon, a new product for the treatment of rheumatic disease.

HOFFMANN-LAROCHE, INC. 66
Nutley, N. J.
You are cordially invited to visit the Roche booth where our medical representatives will provide you with the latest information and literature on our products. Featured will be Madribon and Tigan.

KREMERS-URBAN CO. 71
Milwaukee, Wis.
Kremers-Urban features at its booth: Levsin, most effective visceral antispasmodic . . . Salimeph Forte, combining all of the advantages of massive salicylate therapy and mephenesin in easy-to-swallow capsule-shaped tablets . . . kutapressin for the control of capillary bleeding and for rebellious skin diseases . . . Ku-Zyme, digestant for enzymatic imbalance . . . Milkinol, unique, self-emulsifying liquid petrolatum, the modern non-habit forming constipation correctant for all age groups . . . Kudrox (double strength) doubly effective antacid-demulcent-cholecystokinetic, for relief of gastro-intestinal disturbances and also as an adjunct in the peptic ulcer regimen.

ELI LILLY AND CO. 36
Indianapolis, Ind.
You are cordially invited to visit the Lilly exhibit located in space No. 36. The Lilly sales people in attendance welcome your questions about Lilly products and recent therapeutic developments.

LLOYD BROTHERS, INC. 15
Cincinnati, Ohio
Welcome to the Lloyd Brothers exhibit. Our professionally trained sales representatives will be happy to greet you and discuss the merits of our products in your practice.

J. A. MAJORS CO. 29
Dallas, Texas
The latest publications of W. B. Saunders Company will be on display for your examination. Some of the more recent ones are as follows: Gardner- Textbook of Anatomy; Poppen- Atlas of Neuro-surgery; Bakwin-Behavior Disorders in Children; 1960 Current Therapy; Christopher- Textbook of Surgery and Roberts- Difficult Diagnosis.

MALTBIE LABORATORIES 3
Belleville, N. J.
Maltbie Laboratories features the new dermatologic ointment, Caldecort, containing calcium undecylenate, hydrocortisone and neomycin for a comprehensive therapy of skin conditions caused by fungi, bacteria or

allergy. Also exhibited are: Desenex, most widely prescribed for athlete's foot; Nesacaine, a safe, potent and rapid-acting local anesthetic; Bifran, for the management of the over-weight patient; and Cholans, for the treatment of hepatobiliary dysfunction.

MEDICAL PROTECTIVE CO. 33
Fort Wayne, Ind.

With exceptional proficiency in defense, so essential to the Doctor's protection today, The Medical Protective Company offers unexcelled coverage in any claim or suit for damages based on professional services rendered or which should have been rendered. Its experience from the successful handling of 80,000 claims and suits during 61 years of Professional Protection Exclusively is unparalleled in the professional liability field.

THE WM. S. MERRELL CO. 39
Cincinnati, Ohio

For the first time, an effective anorexic agent is *recommended* for cardiac, hypertensive, and diabetic patients. New Tenuate is a hunger control agent so free of CNS stimulation it is used for nighttime hunger.

Tenuate and other Merrell drugs will gladly be discussed by Merrell men.

C. V. MOSBY CO. 60
St. Louis, Mo.

New ideas, new knowledge, new research and technique—all are waiting for you in the newest Mosby books for 1959 and 1960. Come in. Look over these books at your leisure and convenience. If you wish his assistance, our experienced representative will be happy to discuss any book with you.

V. MUELLER & CO. 27
Chicago, Ill.

We are pleased to make our first Florida Medical Association meeting. We are now fully represented in Florida and would like to take advantage of our complete instrument display. Please bring any of your instrument problems to our men in attendance at the booth.

THE NATIONAL DRUG CO. 19
Philadelphia, Pa.

Tepanil and Orenzyme are being featured at our exhibit.

Tepanil—for weight control. A completely new compound that curbs the appetite without CNS stimulation. TEPANIL is safe, well tolerated, and suitable for evening use, on patients of *all* ages.

Orenzyme—the *first oral* anti-inflammatory enzyme tablet on the market. Orenzyme is *swallowed*—just like an aspirin tablet. Orenzyme is indicated for treatment of any acute inflammatory process when swelling slows recovery.

AVC Suppositories—a completely new vaginal suppository providing all the proven effectiveness of AVC Improved Cream. AVC Suppositories are highly effective in controlling all the common types of vaginal infections—trichomonal, bacterial and fungal.

Please stop by.

ORGANON, INC. 68
Orange, N. J.

Physicians are cordially invited to visit the Organon booth for information on useful therapeutic specialties. Included among these will be:

Durabolin—A new, safe, potent, long-acting biologic stimulant indicated in all conditions where a tissue-building action is desired. Durabolin provides its potent tissue-building effects without the drawbacks and dangers characteristic of tissue-building steroids. No masculinization occurs in recommended dosages. No progestational effects can occur.

Organon representatives will gladly discuss these specialties with all interested physicians.

ORTHO PHARMACEUTICAL CORP. 55
Raritan, N. Y.

At booth fifty-five Ortho is proud to present its new blood clot dissolving agent, Actase Fibrinolysin (Human). Indicated specifically in thrombophlebitis and pulmonary embolism, Actase is a naturally derived blood fraction.

Ortho is also introducing a new monilicidal vaginal cream, Sporostacin. This emollient white cream contains the unique chemical chlordantoin which, because of its structure, has the unusual ability to penetrate the monilial membrane. Clinically proved, Sporostacin Cream is the treatment of choice in monilial vaginitis.

Representatives on hand will be happy to discuss these and their other products with you.

PET MILK CO. 58
St. Louis, Mo.

We will be pleased to have you stop and discuss the variety of time-saving material available to busy physicians. Our representatives will be on hand to discuss the merits of "Pet" Evaporated Milk for infant feeding and Instant "Pet" Nonfat Dry Milk for special diets.

PFIZER LABORATORIES 61
Brooklyn, N. Y.

The Pfizer Laboratories' display has been specifically arranged for your convenience and to give you the maximum in quick service and product information.

To make your visit worthwhile, technically trained Medical Service Representatives will be on hand to inform you of the latest developments in Pfizer Research.

R. J. REYNOLDS TOBACCO CO. 73
Winston-Salem, N. C.

Welcome to the R. J. Reynolds Tobacco Company Exhibit! You are cordially invited to receive a cigarette case (monogrammed with your initials) containing your choice of Camel, Winston Filter, Menthol Fresh Salem, or Cavalier King Size Cigarettes.

A. H. ROBINS CO., INC. 52
Richmond, Va.

Dimetane, the antihistamine unsurpassed in efficacy, and demonstrated in the literature as having the lowest incidence of undesirable side effects, is featured at the A. H. Robins exhibit. Co-featured is Donnatal, the classic combination of natural belladonna alkaloids and phenobarbital. Also shown are the antirheumatics in the Pabalate "family"; and Robaxin (tablets and injectable), which relieves skeletal muscle spasm without sedation.

ROSS LABORATORIES 10
Columbus, Ohio

Ross Laboratories, who also manufactures Similac, features Similac with iron, a new prepared infant formula supplying 12 mg. of ferrous iron per quart of formula. Similac with Iron is designed for use when iron is indicated in infancy, for maintenance of iron stores, to provide prophylaxis against iron-deficiency anemia and to support the normal diet. Some special indications for use are following placental or traumatic blood loss, for prematures and twins, for the pallid, irritable, anorectic infant with an unsatisfactory blood picture and following prolonged infection or diarrhea.

SANBORN CO. 7
Waltham, Mass.

New Electrocardiographs of advanced design and function, as well as latest models of other instruments for diagnostic use, will be displayed and demonstrated at the Sanborn Company Booth No. 7.

Demonstrations and/or data will also be available on Sanborn instruments for biophysical research—single and multi-channel recording systems, monitoring oscilloscopes and physiological transducers.

SANDOZ PHARMACEUTICALS 47
Hanover, N. J.

Sandoz Pharmaceuticals cordially invites you to visit our display at booth #47.

Mellaril—the first potent tranquilizer with a selective action (i.e.—no action on vomiting centers). This unique action gives specific psychic relaxation with safety at all dosage levels.

Cafergot PB—the most effective oral medication for the relief of migraine headache with G. I. disturbance accompanied by tension.

Plexonal — preferred daytime sedative — relaxant. Superior to both the barbiturates and Meprobamates.

Any of our representatives in attendance, will gladly answer questions about these and other Sandoz products.

SCHERING CORP. 57
Bloomfield, N. J.

Schering Corporation cordially invites members of the Florida Medical Association to visit the Schering technical exhibit. Featured products include Fulvicin, the first oral antifungal antibiotic for ringworm; Deronil, the corticosteroid of choice; Polaramine, the lowest dosage antihistamine, and Trilafon, the tranquilizer and antiemetic of unexcelled efficacy.

G. D. SEARLE & CO. 72
Chicago, Ill.

You are cordially invited to visit the Searle booth where our representatives will be happy to answer any questions regarding Searle Products of Research.

Featured will be Mornidine, the new synthetic recommended to prevent or stop nausea and vomiting associated with pregnancy, anesthesia, radiotherapy and gastroenteritis; Dartal, the new tranquilizing agent which controls activities associated with anxiety states and other neuroses; Enovid, the new synthetic steroid for treatment of various menstrual disorders; and Nilevar, the new anabolic agent.

Also featured, will be Vallestril, the new synthetic estrogen with extremely low incidence of side reactions; Pro-Banthine and Pro-Banthine with Dartal, the standards in anti-cholinergic therapy; and Dramamine and Dramamine-D, for the prevention and treatment of motion sickness and other nauseas.

SHERMAN LABORATORIES 9
Detroit, Mich.

Severe asthmatic attacks are not merely relieved, but *terminated* in 10 to 20 minutes by Elixophyllin, given *orally*. In milder attacks, its speed has been described as "instantaneous."

Vital capacity increases were noted as soon as 5 minutes after administration. Pick up these data and reports on their clinical significance at the Sherman booth.

SURGICAL EQUIPMENT CO. 38
Miami, Fla.

We cordially invite you to visit our booth, where our courteous salesmen will show you the latest types of equipment and surgical supplies.

SWIFT & CO. 45
Chicago, Ill.

Swift's Baby Foods, the most complete variety of meat and egg yolk products—plus High Meat Dinners —for your infant patients, are being featured at the Swift exhibit. Reprints of Swift sponsored clinical studies investigating the role of meat in the infant's diet including the results of research on meat and its effect on infant iron metabolism, are available. Also obtainable is the booklet "A Better Start in Life" prepared especially for the new mother.

S. J. TUTAG & CO. 6
Detroit, Mich.

S. J. Tutag & Company will introduce the new tranquilizer—Sonazar tablets. Sonazar is a unique combination of proven relaxants and sedative-like drugs plus Tulyn for fast—safe—predictable tranquilizing action without undesirable side effects.

You are cordially invited to stop and visit at Booth #6, get the full information regarding Sonazar and receive a memento of the convention.

THE UPJOHN CO. 46
Kalamazoo, Mich.

Professional representatives of The Upjohn Company are eager to contribute to the success of your meeting. We are here to discuss with you products of Upjohn research that are designed to assist you in the practice of your profession. We solicit your inquiries and comments.

VANPELT & BROWN, INC. 31
Richmond, Va.

VanPelt and Brown extend a cordial invitation to visit their exhibit where representatives will be happy to answer questions and supply clinical samples of their products.

WESTWOOD PHARMACEUTICALS 62
Buffalo, N. Y.

Westwood invites physicians to stop by their booth to discuss their unique dermatological products:

Fostex Cream	Fostex Cake
Sebulex	Lowila Cake
Lowila Emollient	

These products are particularly suitable for personal use by physicians and their families, who may be plagued with dandruff, acne, dry itchy skin and sensitivities to soap. Register, so that we may send prescription units to your home.

WHITE LABORATORIES 54
Kenilworth, N. J.

White Laboratories exhibit features Disomer, a new scientific contribution in the treatment of allergic disorders. Disomer's pure antihistamine action becomes a pharmacologic fact because Disomer "sheds the molecular dross," and emerges close to the therapeutic ideal of pure antihistamine activity.

BURROUGHS WELLCOME & CO. 42
Tuckahoe, N. Y.

The extensive research facilities of 'B. W. & Co.', both here and in other countries, are directed to the development of improved therapeutic agents and techniques.

An informed staff will be at our booth to discuss our products and latest developments.

E. R. SQUIBB & SONS 51
New York, N. Y.

E. R. Squibb & Sons has long been a leader in development of new therapeutic agents for prevention and treatment of disease. The results of our diligent research are available to the Medical Profession in new products or improvements in products already marketed.

At booth #51, we are pleased to present up-to-date information on these advances for your consideration.

WARNER-CHILCOTT LABORATORIES 56
Morris Plains, N. J.

Nardil—Safe, new, rapidly effective treatment for true (endogenous) depression, restores depressed and despondent patients to reality with no toxic effect on blood, liver or kidneys.

Gelusil—the physician's antacid—for the relief of gastric hyperacidity and management of peptic ulcer. Clinically superior because it is nonconstipating. Ideally suited for the peptic ulcer patient.

PRESIDENT'S PAGE

Our Other Responsibility

Our second resolution for 1960 was — "and further, be it resolved that we be good citizens as well as good physicians and assume our other responsibility as leaders in all phases of our community life, including politics."

Doctors of Medicine must of necessity be educated. By their particular type of experience, physicians become much more than ordinarily familiar with all of the problems of mankind. They develop a factual realization of their neighbor's weaknesses or frailties and an unusual appreciation of his strength and accomplishments. It is quite natural that their patients, friends and neighbors turn to them for counsel and advice in many matters other than just health. All physicians recognize and accept this confidence placed in them by their individual patients. Unfortunately, altogether too few physicians recognize that this confidence placed in them calls for leadership on their part.

One of the greatest problems facing this Nation today is the apathy among its people—a lack of interest or participation in community life or public affairs. There is too much of the spirit of "let George do it" and then of not being satisfied with what "George" has done. This apathy is growing to the proportions of a community disease. "Physician heal thyself." Cure your own apathy and accept the position of leadership your public expects of you, and then we can cure the apathy of the rest of the people.

Elections of our government officers at all levels are soon to occur. If we are to preserve our individual freedom and democracy, a majority of the citizens must go to the polls and that majority must be informed and thinking, freedom-loving Americans. If we are to preserve our freedom way of life, we must preserve our democratic laws. To do so we must begin, not where the laws are made, but where the lawmakers are made. We must start in the precinct in each individual polling place.

Colleagues, I wish to remind you that there are many good candidates for public office at all levels. I wish to urge you to pick the one for each office who you sincerely believe will support the kind of law-making and government best for you and those who have that confidence in you as their physician and advisor. When you have selected your candidate, you need do only two more things. Tell him that you are supporting him, but most of all tell all of your public whom you are supporting and why.

THE JOURNAL
OF THE
FLORIDA MEDICAL ASSOCIATION

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The Seven Lean Kine

How Joseph interpreted Pharoah's dreams and thus prevented a great calamity from befalling the Egyptians is a Bible Story well recounted. What is not known is how the great Pharoah living in the midst of plenty was able to convince himself and his people that only by sacrifice in times of great prosperity would they survive. Would that this quality possessed by Pharoah which prevented a surfeited life from blinding him and his people to the dangers of the morrow were known to the American physician of today.

It is expected that this session of the Congress will pass definite legislation relating to care of the aged. It is most likely that the highly publicized Forand Bill will be supplanted by legislation framed by the Department of Health, Education, and Welfare. Such a bill will then be referred to Congressional Committees before whom various concerned and unconcerned persons will make long and erudite statements. Before the Committee's version of the Bill is returned to the Congress, the American Medical Association will send copies of it to the various State Medical Societies who will pass it on to the County Medical Societies where an apathetic membership will be called into emergency session to consider action on something of which it knows nothing. By the time the local Medical Societies have opposed whatever it was they were to consider, the Committee's Bill will probably have passed the Congress anyway. No crystal ball is needed for this prediction as it merely represents a repetition of a Medicare Incident of recent years.

Physicians, as they engage in small groups in hospital corridors, will grumble about the imminence of Socialized Medicine. They will damn labor for getting more fringe benefits which include medical care of a type not to their liking. They will label as communists those social workers and planners whose job it is to get adequate medical care for all. They will curse insurance companies for not selling health policies which would give their patients total medical coverage for a token premium. They will call two-faced their elected representatives who have passed such a bill even though the physician probably does not even know his representative's name. Thus it has been—thus it will probably be. But

some of the ones whom the physician condemns are those who have really prevented socialized medicine from occurring even if because of their own vested interests. Insurance companies would lose their millions of health, accident and hospitalization policies and other associated business. Labor would lose control of tremendous amounts of money which their health and pension plans have accumulated for their treasuries.

It is time that the American physician realized he can no longer project his deficiencies on those who must deal with his each day. The physician cannot expect others to solve his problems in a way he would like them solved when the average physician admits to no problems except the care of his patients as he desires to treat them.

Perhaps if the average American physician did not have as many patients as he could possibly treat, he might become slightly more aware of his default in not aiding in the formulation of plans to answer the health problems of today and tomorrow. His utter disinterest in anything in medicine other than the immediate treatment of patients which gratifies his ego and his economic needs will be the cause of the future destruction of medical practice as it is now known in America. All criticisms leveled at the American physician today cannot be answered by the statement that American medicine gives the best treatment in the world. To defend the status quo merely means that the American physician is neglecting his duty to give the world's best medicine to all groups at a price they can afford.

What American medicine needs today is a Joseph and a Pharoah. A Joseph to interpret in simple piercing language the deficiencies in present day medical practice which are causing public discontent. A Joseph to plan for the future with concrete workable ideas. A Pharoah to make these plans voluntarily acceptable to the physicians whose gratification of the moment blinds them to tomorrow's necessities. Our years of plenty are at hand. The seven fat-fleshed kine are about to be devoured.

J. J. L.

Postgastrectomy Malnutrition

For many years the patient who had had a gastric resection in the treatment of peptic ulcer was followed by his physician, whose primary concern was the development of a malfunctioning stoma or a marginal ulcer, with little attention being paid to the general state of health or well-being of the patient. Fortunately, today, other postoperative complications, such as the dumping syndrome, anemia and malnutrition, are being recognized, and recent reports would indicate that these complications, especially malnutrition, are far more prevalent than was realized formerly.

It is generally agreed that 50 per cent of patients who have had a subtotal resection for benign ulcer will lose 10 per cent or more of their ideal weight. To the obese person who has been trying unsuccessfully for years to lose weight, this loss may come as a welcome event. And, indeed, in many middle-aged patients, a moderate loss in weight is rather desirable. So the question can be raised, is postgastrectomy malnutrition a real problem, and if so, what is its incidence and severity? There is no unanimity of opinion on this subject, but certain statements can be documented. Patients have died of malnutrition alone, fortunately very few, and an appreciable number (10 to 15 per cent is a reasonable estimate) are malnourished to the point of affecting seriously their ability to carry on their usual activities. It is unlikely that malnutrition is of any particular consequence in the remainder of this group.

There are two obvious causes of malnutrition following gastric resection: (1) inadequate caloric intake, and (2) malabsorption. The decreased food consumption is usually attributed to a small gastric reservoir, "dumping," the afferent loop syndrome, and to anorexia, regardless of cause. Malabsorption is probably a digestive rather than an absorptive defect.

Granting the existence of postgastrectomy malnutrition, what can be done about it? If merely insisting upon an adequate intake of food were the answer, there would be no problem. A number of these patients, however, either cannot or will not increase their food intake, and some whose intake is apparently adequate still fail to

gain. This would seem to be an error of absorption, due to inadequate digestion. Yet nothing has been discovered which will correct this defect satisfactorily. Pancreatic enzymes, duodenal extract, and bile preparations have all been tried singly or collectively without appreciable success.

Recently there have been several reports suggesting another possible factor, namely utilization. In a carefully controlled study using testosterone, it has been shown that the gain in weight regularly noted in postresection malnutrition was not due to increased dietary intake but rather to the anabolic effect of the hormone. Although no side effects were reported by these authors, others have found its androgenic properties so serious as to preclude its use in certain cases. Recently another anabolic agent, norethandrolone, has been found effective in promoting gain in weight with minimal or no side effects.

Intelligent management of the case with careful attention to the diet and the use of digestants and anabolic agents should yield good results in most patients. It is unwise, therefore, to deny the "ulcer cripple" the benefit of surgery, when a subtotal resection, in all probability, would restore him to useful life. When elective surgery is being considered, however, the possibility of malnutrition with resulting disability especially in the undernourished patient should be borne in mind. It is sometimes wiser to "bear those ills we have than fly to others that we know not of." Any operation is serious, and surgery, like marriage, "is not by any to be entered into unadvisedly or lightly." In elective surgery, the decision should not be made by the surgeon alone but rather by a team consisting of a surgeon, an internist, and even a psychiatrist in some cases. After surgery the patient should be followed by the same team rather than by an individual physician.

Julian M. Ruffin, M.D.
Professor of Medicine
Chief of Service,
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Duke University Medical Center
Durham, North Carolina

Jacksonville
1960 Convention City

For its Eighty-Sixth Annual Meeting the Florida Medical Association is returning to its native heath for the first time since the war years of the forties. Meetings were held in Jacksonville in 1941 and 1943, but the meeting scheduled for 1945 was canceled because of war restrictions. The last time the Association met there was in 1946.

When the members of the Association gather at the Hotels Robert Meyer and George Washington in the Gateway City on April 8-11, 1960, they will be meeting close to hallowed ground. Only two blocks east of the hotels the Florida Medical Association was founded 86 years ago. Realizing the need for medical organization in the state, the Duval County Medical Society sent out a call in November 1873 to the other medical societies and to individual physicians throughout the state which resulted in a meeting on Jan. 14, 1874, in the home and office of Dr. A. S. Baldwin on the northeast corner of Adams and Laura Streets. At that meeting an organization was effected under the title of "The Medical Association of the State of Florida," and Dr. Baldwin became the Association's first president. In addition to those from the Duval County Medical Society, representatives were present from the Columbia, Leon, Marion, Nassau and St. Johns county medical societies.[1]

The original Constitution and By-Laws of the Association were adopted at the second meeting of the Association, held in February 1875, also in Jacksonville. In this year of 1960 when the recently revised Charter and By-Laws are a major item of interest at the Annual Meeting, it is noteworthy that the Association's great success and phenomenal growth through more than eight decades has sprung from adherence to the objectives set forth by the founding fathers who sought to effect an efficient organization throughout the state, "to promote union, harmony and good feeling among the members, to establish and

The home of Dr. A. S. Baldwin in Jacksonville in which the Florida Medical Association was organized on Jan. 14, 1874.

maintain a high standard of professional acquirement and ethics, and to inspire interest and zeal for the cultivation of medical science and literature."[1]

Today, the site of Dr. Baldwin's home lies in the heart of the teeming metropolis that is Jacksonville 1960. Gateway to Florida by land, air and sea, this cosmopolitan city retains the friendliness and hospitality of the Old South. The Azalea City takes pride in the scenic and recreational attractions of its 184 parks. Its people are especially proud of its many beautiful churches, and its numerous cultural advantages include the Jacksonville Symphony Orchestra, the Jacksonville Junior Symphony Orchestra, one of the finest Little Theatre groups in the country, the Children's Theatre, the Children's Museum, the Art Center, the outstanding new Garden Center, the Friday Musicale which is Florida's oldest music club, the Civic Music Association, the Jacksonville Forum, the Guild Players, the Jacksonville Choral Society and, in addition, a large number of outstanding civic organizations. The YMCA and the YWCA, both very active, now occupy beautiful new buildings. Besides the many public, private and special schools in the community, Jacksonville University with its 200 acre waterfront campus of nine handsome modern buildings and a student enrollment of 2,250 this year is a rapidly growing cultural asset of ever increasing importance.

The Main Street bridge overshadows a part of the municipal parking area.

Jacksonville has seven general hospitals—Baptist Memorial Hospital, Brewster Hospital, Duval Medical Center, Riverside Hospital, St. Luke's Hospital, St. Vincent's Hospital and the United States Naval Hospital. Of these, St. Luke's Hospital is the oldest hospital in Florida, founded in 1873, and Baptist Memorial Hospital, now in its fifth year of operation, is the most recent one to serve the Jacksonville area. The Jacksonville Hospitals Educational Programs, Inc., one of the first organizations of its type in the nation, develops and operates a coordinated program among member hospitals for the training of interns, residents and other professional personnel in Jacksonville. This city is also the headquarters of the Florida State Board of Health. With appropriate ceremonies last year the Board named its new $600,000 central laboratory building the Henry Hanson Building, in honor of a Jacksonville physician who won international renown in the field of control of tropical diseases, and its new $500,000 administration building the J. Y. Porter Building for the Key West physician who became Florida's first State Health Officer.

Tremendous strides have been made in recent years in transforming the city into an industrial center, a distribution point and a popular location for the establishment of insurance company home offices and railroad headquarters. Its position as a great regional center received considerable stimulus with the erection of the Atlantic Coast Line Railroad's new general headquarters building, now nearing completion, on a downtown site overlooking the St. Johns River. On the opposite bank, the imposing 22 story South Central Home Office of the Prudential Insurance Company of America overshadows the neighboring Baptist Memorial Hospital and the Marshall Taylor Doctors Building. In this insurance capi-

tal of the Southeast there are 17 home and regional offices, and 18 major general insurance agencies represent 172 companies. Handsome home office buildings of the various insurance companies dot the city's skyline. Sears Roebuck and Company has recently opened its largest retail store, which occupies two blocks on downtown Jacksonville's historic Bay Street adjoining the city's immense riverfront parking area. Adorning the waterfront beyond the parking area are two imposing new structures, the Duval County Court House and the City Hall. A new City Auditorium will soon add to the beauty of the riverfront in the downtown section and fill an important need in this popular convention city. The new Hotel Robert Meyer, where the Association's 1960 convention will be in session, bears striking testimony to the community-wide effort which is making Jacksonville one of the fastest growing cities in the nation.

The banking capital of the state, Jacksonville is headquarters for three large Florida banking groups operating in 28 cities throughout the state. It is also the home of the Federal Reserve Bank of Atlanta (Jacksonville Branch).

Its strategic location astride the beautiful St. Johns River only 15 miles west of the Atlantic Ocean has long made Jacksonville an important port. It has an excellent landlocked natural harbor with a 34 foot channel to the Ocean and is the largest deep water port in the south Atlantic area. Over 100 world ports are served through its facilities. The Atlantic Intracoastal Waterway, which extends from Trenton, N. J., to Miami, also serves the city.

This segment of the expressway network serves the South Jacksonville area and U. S. Highway 1 traffic.

Jacksonville's impressive $100 million dollar Expressway System is being speeded to an expected completion by the end of this year. Its two new bridges over the St. Johns River and many miles of connecting highways are already in use.

The Gateway City is an important military center, especially for the Navy. Immediately adjoining the city is the Jacksonville Naval Air Station, a few miles to the east is the gigantic

The carrier basin is a part of the Navy's facilities at historic Mayport.

Mayport Naval Air Station and on the southwest is the Cecil Field Naval Air Station.

The city is proud of its huge Sports Center, which includes the nationally famous Gator Bowl seating 46,000 and the new Baseball Park, seating 10,000. A third attraction in process of development is the Sports Coliseum with a seating capacity of 13,000.

In Jacksonville one is never more than minutes away from unexcelled swimming, boating and fishing. A short drive from downtown Jacksonville leads to "The World's Finest Beaches"—Atlantic, Neptune, Jacksonville and Ponte Vedra. There one may drive on or relax on 30 miles of smooth, hard-packed gently shelving sand or enjoy all sorts of seaside amusements.

With its wide variety of navigable waters, Jacksonville is the boat enthusiast's and the fisherman's paradise. Water skiing, sail and speed boating and fishing are among the favorite water activities. There are more than 400 varieties of fish in the salt and fresh waters in and around the city. Skin diving and spear fishing are also popular in this area.

Five private country clubs and a private yacht club provide boating, tennis, golf, swimming and social activities. Other attractions are scenic and historic tours, Class A baseball, gay night life, dog racing, stock car racing and at a new track Florida's only harness and quarter horse racing.

The city destroyed by fire in 1901 has rise from its ashes to be a leader in the Southeast and Florida's chief industrial city, boasting a population in the Greater Jacksonville Area fast approaching half a million. Despite its rapid growth in industry, commerce and population, there remains much of the courtesy and hospitality of the Old South. An atmosphere of friendliness and cooperative effort is everywhere apparent. The Jacksonville of today, with its towering buildings, its industrial plants, its transportation network and its cultural and spiritual growth is a wonderful place to live, work and play—and visit. Come to the Annual Meeting next month and enjoy it.

1. Merritt, Webster: A Century of Medicine in Jacksonville and Duval County, Gainesville, University of Florida Press, 1949, pp. 75-76.

Reservations

Hotel reservations for the Association's Annual Meeting, April 8-11 in Jacksonville, should be made direct with the Hotels Robert Meyer and George Washington.

Highlands County Medical Society Inaugural Meeting

An important milestone of medical progress in Florida was celebrated when the Highlands County Medical Society held its inaugural meeting and buffet supper in the Jacaranda Hotel at Avon Park on Jan. 20, 1960. Every member of the new society was present except one who was unavoidably detained out of town. Every doctor's wife was also present except one who was out of the state.

The officers of the society are Dr. Hubert W. Coleman, President, Dr. Carl J. Larsen, Vice President, and Dr. Samuel A. King, Secretary-Treasurer, all of Avon Park. Dr. Coleman presided at the meeting and welcomed the members and guests. Among the distinguished visitors were Dr. Ralph W. Jack, of Miami, President of the Florida Medical Association, and Mrs. Jack; Mrs. Wendell J. Newcomb, of Pensacola, President of the Woman's Auxiliary to the Florida Medical Association; Dr. John M. Butcher, of Sarasota, and Mrs. Butcher, who is President-Elect of the Auxiliary, and Judge and Mrs. Mervin Rehrer of Avon Park.

Dr. Jack was the featured speaker of the evening, and it was his privilege to present to Dr. Coleman the society's charter. In so doing, he mentioned that the Highlands County Medical Society is the thirty-ninth component society to be formed within the framework of the Florida Medical Association and the first to be admitted under the Association's new By-Laws drawn up in May 1959 and recently ratified.

In his address, Dr. Jack stressed the aims of the Florida Medical Association—"to care for the people of our area, to further the cause of Medicine, and to strive constantly for advancement and improvement of doctors and medical care in the communities." He specifically warned against apathy, especially as it pertains to the Forand Bill, which permits the infiltration of Socialism, the creeping cancer of society. "May each of us," he said, "use our influence in grassroots fashion to educate the public so that they may go to the polls better informed and better able to elect legislators who will avoid this faulty type of legislation."

Dr. Jack also addressed the doctors' wives, who met with Mrs. Newcomb and Mrs. Butcher to organize a Woman's Auxiliary to the Highlands County Medical Society.

County Medical Society Presidents and Secretaries Hold 1960 Annual Conference

The Second Annual Conference for County Medical Society Presidents and Secretaries, sponsored by the Florida Medical Association, convened on Saturday afternoon, Jan. 16, 1960, at the Hotel Robert Meyer in Jacksonville and continued until noon on Sunday. Dr. Ralph W. Jack, of Miami, President of the Association, presided over the opening session. In his welcoming remarks he stated that the purpose of the Board of Governors in arranging the Conference as an annual feature of the Association's program was to strengthen professional relations with the component societies through their officers, to improve communications, and to make the task of the newly elected officers easier by explaining in some detail the plans, policies, precedents, currently active projects and methods of operation at the state level. In addition, the Board sought to learn from the chosen leaders the feelings, wishes and reactions of the members of the various constituent societies.

Dr. Thad Moseley, of Jacksonville, Chairman of the Committee on Scientific Work, then outlined the program for the 1960 Annual Meeting of the Association, to be held in Jacksonville on April 8 to 11. He explained the radical changes in the plans for the meeting with the entire program scheduled over a long weekend in the expectation that more physicians will attend.

Discussing "Current Policies and Programs of the A.M.A.," Dr. Ernest B. Howard, of Chicago, Assistant Executive Vice President of the American Medical Association, reviewed 15 salient features of that association's comprehensive program. Following his address, Dr. Jere W. Annis, of Lakeland, the Association's immediate Past President, spoke on "The Responsibilities of the County Medical Societies." He urged the officers of the county societies as acknowledged leaders of medicine in their respective communities to provide a positive program for the advancement of the profession in those communities, scientifically, socially and civically.

Dr. Samuel M. Day, of Jacksonville, Secretary-Treasurer, presented an interesting discussion of "The New FMA Charter and By-Laws." He explained the Councils and the various committees composing them and emphasized new provisions in the By-Laws including the new membership classifications. The Chairman of the Medicare Mediation Committee, Dr. Burns A. Dobbins Jr. of Fort Lauderdale, reported on the government's present position on the status of Medicare.

Dr. Ralph W. Jack, President of the Florida Medical Association, presided over the afternoon session of the Conference.

Dr. Ernest B. Howard of Chicago, Assistant Executive Vice President of the American Medical Association, discussed the policies and programs of that Association.

Assuring the county society officers that the Florida Medical Foundation is now firmly established, its President, Dr. John D. Milton of Miami, reminded them that contributions are tax-deductible and that the Foundation now has assets of more than $11,000. He was followed by Dr. Floyd K. Hurt, of Jacksonville, Chairman

Dr. Wachtel

Dr. Day

of the Association's Committee on Medical Economics, who described the newly established Florida Medical Association Investment Trust and also discussed the insurance program for Civil Service employees.

"Forand Type Legislation and Aging" was the timely subject presented by Dr. H. Phillip Hampton, of Tampa, Chairman of the Committee on Legislation and Public Policy. He explained that the Committee was meeting the following day with representatives of the American Medical Association to discuss detailed and concerted plans to defeat this legislation, now before the House Ways and Means Committee, so that it will not become a campaign issue in the forthcoming presidential election.

Concluding the afternoon session, Dr. Jack emphasized the challenge of free medicine versus political medicine which now faces the medical profession and the public. He urged all physicians to make every effort to cure the "socialistic cancer" which will destroy the American way of life as surely as any other cancer will kill its host.

Following a social hour and buffet supper, the informative motion picture entitled "On Call to a Nation" was shown. This television documentary of the British Broadcasting Corporation, commemorating the tenth anniversary of the National Health Service in Great Britain, aroused keen interest.

The morning session on Sunday was devoted to a profitable discussion of diversified subjects dealing with the mutual programs and problems of the component society officers. Dr. Leo M.

Representatives of 21 component county medical societies gathered for the Conference.

Wachtel, of Jacksonville, President-Elect, presided. At his request Mr. Charles Johnson, of Chicago, representing the Field Division of the American Medical Association, outlined the plan county medical societies should implement with all possible speed in combating the Forand Bill. The topics then discussed covered a wide range from medical exhibits at county fairs, press and public relations, "Future Doctor" clubs for high school students, and promotion of other careers in the health field to the care of private patients' emergencies, the improvement of attendance at county society meetings, and the Dade County Medical Association's epic program of polio immunizations with the attenuated oral vaccine which can be given in one dose at any age. At Dr. Wachtel's request, Dr. Franklin J. Evans, of Miami, described the ambitious project now under way to administer the new Cox vaccine to 520,000 people 40 years of age and under in the Greater Miami area. Never before in the United States has an attempt been made on so large a scale to eradicate completely a disease from a community.

The lively interest stimulated by the meeting proves the worth of such an annual conference and should insure representation by every component society next year. The officers in attendance and the county societies they represented were:

ALACHUA: Dr. Richard E. Perry, Gainesville, secretary.

BAY: Dr. Donald H. Anderson, Panama City, president; Dr. John L. Fishel, Panama City, secretary.

BREVARD: Dr. Cyrus E. Warden, Melbourne, president; Dr. Arthur C. Tedford, Melbourne, acting secretary.

BROWARD: Dr. Burns A. Dobbins Jr., Fort Lauderdale, president-elect.

DADE: Dr. Franklin J. Evans, Coral Gables, president; Dr. DeWitt C. Daughtry, Miami, secretary.

DUVAL: Dr. Floyd K. Hurt, Jacksonville, president; Dr. Sidney Stillman, Jacksonville, president-elect; Dr. Albert D. Rood, Jacksonville, secretary.

HIGHLANDS: Dr. Hubert W. Coleman, Avon Park, president.

HILLSBOROUGH: Dr. Frank A. Massari, Tampa, secretary.

LEON - GADSDEN - LIBERTY -WAKULLA JEFFERSON: Dr. Edson J. Andrews, Tallahassee, president.

MANATEE: Dr. Willett E. Wentzel, Bradenton, president; Dr. John A. Shively, Bradenton, secretary.

MARION: Dr. William C. Butscher Jr., Ocala, secretary-treasurer.

ORANGE: Dr. W. Dean Steward, Orlando, president; Dr. Robert L. Stephens, Orlando, president-elect.

PALM BEACH: Dr. Willard F. Ande, West Palm Beach, president.

PASCO - HERNANDO - CITRUS: Dr. S. Carnes Harvard, Brooksville.

POLK: Dr. Chas. Larsen Jr., Lakeland, president.

PUTNAM: Dr. Roy E. Campbell, Palatka, president.

ST. LUCIE-OKEECHOBEE-MARTIN: Dr. Joseph H. Batsche, Fort Pierce, president.

SEMINOLE: Dr. Edwin Epstein, Sanford, president; Dr. Robert J. Smith, Sanford, secretary.

SUWANNEE - HAMILTON - LAFAYETTE: Dr. Frederick T. Mickler Jr., Jasper, president.

VOLUSIA: Dr. James J. Cunningham, Daytona Beach, president; Dr. C. Robert DeArmas, Daytona Beach, president-elect; Dr. John J. Cheleden, Daytona Beach, secretary.

WALTON-OKALOOSA-SANTA ROSA: Dr. Joseph C. Wilson, Fort Walton, president, Dr. William W. Thompson, Fort Walton, secretary.

Association Representatives

Dr. Ralph W. Jack, Miami, President; Dr. Leo M. Wachtel, Jacksonville, President-Elect; Dr. Samuel M. Day, Jacksonville, Secretary-Treasurer; Drs. Jere W. Annis, Lakeland, H. Phillip Hampton, Tampa, Alpheus T. Kennedy, Pensacola, Meredith Mallory, Orlando, and S. Carnes Harvard, Brooksville, members of the Board of Governors; Dr. Thad Moseley, Jacksonville, chairman, Committee on Scientific Work.

Past Presidents, in addition to Dr. Annis, Dr. William C. Roberts, Panama City; Dr. John D. Milton, Miami; Dr. Edward Jelks, Jacksonville; Dr. Homer L. Pearson Jr., Miami.

Others Attending

Dr. Edward R. Annis, Miami, Dade County Medical Association; Dr. Russell B. Carson, Fort Lauderdale, president, Blue Shield; Mr. H. A. Schroder, Jacksonville, executive director, Blue Shield; Dr. Wilson T. Sowder, Jacksonville, state health officer; Dr. Ernest B. Howard, Chicago,

assistant executive vice president, American Medical Association; Mr. Charles Johnson, Chicago, field representative, American Medical Association; Dr. John P. Heard, Decatur, Ga., chairman, Committee on Public Relations, Medical Association of Georgia; Mrs. Wendell J. Newcomb, Pensacola, president, Woman's Auxiliary to the Florida Medical Association; Mr. John F. Wymer Jr., West Palm Beach, administrator, Good Samaritan Hospital, and Mr. Harry T. Gray, Jacksonville, attorney for the Association.

Executive secretaries from component county medical societies included Mrs. Mary K. Murray, Fort Lauderdale, Broward; Mr. M. John Hanni Jr., Miami, Dade; Mr. Marshall Brainard, Jacksonville, Duval, and Mrs. Berneice T. Mathis, Orlando, Orange.

Polk County Medical Association Establishes Imperial Bulletin

The Polk County Medical Association is to be congratulated on its newly established Imperial Medical Bulletin. This noteworthy venture took tangible form in January of this year when the first issue was published. It was pointed out editorially in that issue that the single aim of the publication is to help the practice of medicine in Polk County by providing needed information not otherwise available in readily accessible form and by promoting a closer functioning organization of men and women who know each other and who present high standards of medical practice to their county.

Dr. Charles Larsen Jr., of Lakeland, the incoming president of the association for 1960, voiced this aim in his first president's page in these words: "We trust that our bulletin will be informative . . . It is hoped that it will knit our association closer together, support interest, and stimulate creative and constructive thinking among all of us to produce a better basic unit of organized medicine—your own *county association.*"

The high plane and broad scope of the initial number bespeak success in attaining the avowed objectives. A glance at the table of contents of the 48 page bulletin shows the usual features of a president's page, news items, a calendar of activities, editorial and scientific sections, Auxiliary news, current activities, minutes of meetings, committee reports and letters. In addition, there is provision for such monthly special features as deans of Polk County physicians, introduction of new members, the detail man, civil defense, health organizations, allied professional organizations, the Polk County Health Department and hospital news.

The editor of the new publication is Dr. Willard E. Manry Jr. of Lake Wales. The associate editors are Drs. Purdue L. Gould of Lakeland, George P. Graf of Winter Haven, L. Moffitt Howell of Lakeland, Chester L. Nayfield of Winter Haven, Louis J. Polskin of Lakeland, William A. Rye of Brewster and John W. Smythe of Winter Haven, and Mrs. Joseph Niswonger of Lakeland, representing the Woman's Auxiliary.

The Journal of the Florida Medical Association salutes the Imperial Medical Bulletin and wishes it well as it undertakes its important mission.

Physicians Comment On Excellent Fair Exhibits By County Medical Societies

A record number of county medical societies held highly successful educational exhibits for the public during the 1959 fall fair season: the Escambia County Medical Society in the Pensacola Interstate Fair, October 19-25; the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society in the North Florida Fair, Tallahassee, October 27-31; the Putnam County Medical Society in the Putnam County Fair, Palatka, November 9-16, and the Duval County Medical Society in the Greater Jacksonville Fair, November 12-21. Also, the Polk County Medical Association had an exhibit in the Florida Citrus Exposition, Winter Haven, in mid-January, 1960.

These excellent exhibits represented outstanding individual efforts by each of the respective county societies. In order to provide a more graphic and personalized description of each project, The Journal invited the physicians who had planned and directed the exhibits in each case to send in their comments.

Escambia County Medical Society

The Escambia County Medical Society exhibit at the regional fair here in Pensacola last October was a most unusual and successful exhibit which was produced entirely through local efforts.

The exhibit consisted of two major portions:

First were the exhibits of the two winners of the regional science fair which was held six months or so prior for high school students. The county medical society had given additional prizes for exhibits pertaining to medical sciences. The second portion of the exhibit consisted of the Kolff artificial kidney machine in actual operation with a mannequin in a hospital bed, and another part showing the equipment and technique of cardiac catheterization. An outline of a human form was shown with a glass tube representing the arm veins, et cetera. The catheter could be passed through this tube.

One of the most interesting features was the manning of the exhibit by members of the Pensacola High School Future Doctors Club. These students were given brief outlines describing the techniques of cardiac catheterization and artificial kidney dialysis and they were supervised by a member of the medical society most of the time. The students did a wonderful job of picking up the pertinent points and giving brief lectures and discussions to those viewing the exhibit. The theme of the exhibit was as follows: "Studies of the basic sciences by the youth of today lead to lifesaving medical techniques tomorrow."

We have been told that this was a most interesting and enlightening exhibit. The interest by the crowds attested to this fact.

Jack W. Fleming, M.D., Chairman
Committee on Public Relations

Leon-Gadsden-Liberty-Wakulla Jefferson County Medical Society

Since 1952 the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society has sponsored an exhibit at the North Florida Fair in Tallahassee. The first exhibit was on the subject of the cost of medical care and was constructed by the Florida Medical Association. With the exhibit, the Society offered free blood typing and to each person taking advantage of the service, a card was given on which was recorded his individual blood type. Determination of blood pressure was also offered without charge, and when the pressure was abnormal, the person was told to consult his family physician.

Subsequently, the Society sponsored various exhibits constructed by the American Medical

This exhibit, sponsored by the Duval County Medical Society, is representative of the displays shown by the county medical societies at fairs during the fall and winter season.

Association: "Testing the Drinking Driver," "Farm Accidents," "Life Begins," "Digestion," "Your Glands," and, this past October, "Your Body."

The expense of the space and the shipping cost of the exhibit have been borne by the Florida Medical Association with the local Society furnishing the manpower. Members of the Woman's Auxiliary man the booth from 10 a.m. to 9 p.m., and during the peak hours of 7 p.m. to 9 p.m., two members of the Society are present with the Auxiliary to answer any questions concerning the exhibit.

This has been an excellent public relations program in this section of the state.

FRANCIS T. HOLLAND, M.D., CHAIRMAN
COMMITTEE ON PUBLIC RELATIONS

Putnam County Medical Society

The caption for the Putnam County Medical Exhibit was "Blood in Modern Medicine." This exhibit was displayed during the Putnam County Fair, held in Palatka, November 9-15, 1959.

The exhibit was displayed in a booth measuring 11 by 11 feet, with the major portion of the demonstration on the side and back walls. The center area was left open for the spectators. The wall area to the left depicted the method of blood production in the human and the components of blood. This was worked out in sketch form with charcoal and water colors, utilizing a miniature skeleton, a liver made of moulding clay. The red and white cells were given human form, that is, arms and legs, so as better to produce the effect of motion.

The theme for the back wall was the use of blood in modern medicine and surgery. For this display a 5 gallon glass carboy had been cut in half, suspended neck down, painted red inside. It looked exactly like a massive bottle of blood. From the mouth of the bottle five tubes coursed downward, filled with red dye, to sketched displays depicting the needs for blood. As an example, an operating room was shown in which major surgery was progressing. (Note: I would not recommend the use of such a bottle again. It is a major undertaking to cut one in half. Two glass companies refused to undertake the job.)

The right wall area was set up to show the apparatus used in blood transfusions. Also here a binocular microscope was mounted and slides of normal and abnormal blood were demonstrated. We were fortunate enough to have the blood bank personnel man the booth.

All in all, I would say that the exhibit attracted a great deal of attention. The entire exhibit was worked out locally except for the sign out front which was graciously painted for us by the personnel of the Florida Medical Association, arranged by Mr. Nixon. I did not realize we had this sort of talent.

CHARLES E. BARRINEAU, M.D., PRESIDENT
PUTNAM COUNTY MEDICAL SOCIETY

Duval County Medical Society

All available, appropriate means are being used by the Duval County Medical Society to communicate with the public on the nature of medical practice and of organized medicine. The medium which has permitted the most tangible impact and evaluation has been the exhibit project of the Society at the Greater Jacksonville Industrial and Agricultural Fair, held in the Gator Bowl each fall.

With the consultation and financial assistance of the Florida Medical Association, acceptable exhibit space was obtained approximately 15 feet deep and 40 feet long. Adjacent exhibits were both commercial and educational. The American Medical Association exhibits, "Your Body" and "Seven Paths to Fitness," were the exhibits used in November 1959. Brochures matching the "Seven Paths to Fitness" exhibit were obtained from the American Medical Association. Other giveaway materials included the Duval County Medical Society's brochure prepared for all new residents of the county, the American Medical Association's individual health record card and the Family Health Record booklet. A folding table and several folding chairs complete the physical setup.

All members were urged to participate in manning the booth by announcements at Society meetings and articles and announcements in the Monthly Bulletin. A double post card was mailed to each member giving the main details and asking him to indicate on the return card when he would prefer to be scheduled at the exhibit. Two weeks later a single post card was mailed to each member advising him of the day and hour when he was scheduled at the Fair. The Woman's Auxiliary to the Society scheduled its members between the hours of 1 p.m. and 6 p.m., the hours when physicians were generally not available and when the public attendance at the Fair was low-

est. Physicians, provided with their regular name buttons, came on duty at 6 p.m. and closed the exhibit at 11 p.m. No man or woman was asked to be present for more than two and one-half hours.

Although the physical facilities allowed cold winds and rain to dampen enthusiasm during some days of the Fair, the response by the public and the opportunities for physician-to-layman contact were so great as to justify the project fully. Participation by members of the Society and the Auxiliary was excellent. Completion of the new Coliseum by the City of Jacksonville, in which future fairs will probably be housed, will solve the problems of the physical facilities provided by the Fair, and will permit easy and effective exhibiting by the Duval County Medical Society in future years.

Sanford A. Mullen, M.D., Chairman
Committee on Public Relations

Polk County Medical Association

In mid-January of 1960, the Polk County Medical Association presented the American Medical Association exhibit on Alcoholism at the Florida Citrus Exposition. The exhibit was well received as evidenced by many favorable comments. Family health cards were available for visitors; many of these were taken by the various family groups that visited the Exposition.

In Polk County there is a strong feeling growing toward professional public relations support for the Medical Association. We have started a pilot study with a public relations firm in our area and hope to enlarge this to a year-round professionally directed public relations program.

Times are changing rapidly, and we as a profession of physicians need to choose our position carefully and then make this position known through effective public relations.

George P. Graf, M.D., Chairman
Committee on Public Relations

OTHERS ARE SAYING

Uncertainty in Medicine

Some fields of human endeavor we classify as the exact sciences which in the layman's mind imply utter perfection. The science of physics is thought to belong easily in this realm and perhaps until not too long ago even physicists subscribed to this notion until the brilliant physicist, Heisenberg, came along and enunciated his famous uncertainty principle, which states that events at the atomic level cannot be observed with certainty.

We in medicine speak of the art and of the science of medicine where the science is felt to be the ultimate in scientific accomplishment in regard to life. But a little reflection upon the subject will soon reveal that no matter how scientific medicine should become, there will always be uncertainties to plague our professional lives.

Before a drug is released for human consumption, for example, the law requires that the toxicity of the drug be determined, with this being expressed in terms of the LD^{50}. The LD^{50} is defined as that dose of a drug necessary to cause the death of 50 per cent of the experimental animals. Within this 50 per cent of the animals used there may be litter mates, but not all members of any particular litter may constitute a portion of the 50 per cent that die. We ascribe the survival of those animals in the surviving 50 per cent to such vague attributes as "individual differences." Finally, when the drug is released for human consumption, millions of doses of the drug may be administered with no untoward effects, when lo and behold along comes a person who may suffer severe untoward reactions and even death with a dose of the same drug even much lower than that considered to be "safe." We call this "idiosyncrasy," "therapeutic misadventure," "allergic reaction," "sensitivity" and so forth. This we have seen happen with all of the anesthetics, the antirheumatics, corticoids, the bactericidal and bacteriostatic agents and practically any drug that one can name. When this does occur, we are severely shaken from our state of complacency, but with time we ostensibly recover from the shock and we continue to use the same drug or drugs that caused the damage. Their continued

use is, however, not depreciated since this may be a matter of necessity and the good counterbalancing the risk by far.

In seeing an ailing patient and after all pertinent parameters are taken into consideration as an integrated whole, we may be able to arrive at a diagnosis. Some diagnoses are clear-cut and conform to a general pattern. In other cases the "ring of the bell" may not be "true" and a definitive diagnosis may never become possible even unto death and postmortem analysis. The urge is, however, to attach a label for here only can a modicum of release of the conscience be obtained, while all through the patient's life and even beyond the lack of conviction in our label plagues us for want of *the* answer.

Upon having arrived at a diagnosis, and sometimes even before, patients and patients' families are naturally interested in prognosis. Along these lines we in many instances commit ourselves on the basis of previous experiences with and statistics on the "same" disease, only to find that we may have erred very badly and our "six months-to-live" statement haunts us for years of continued life beyond the last day of the death sentence.

Some years back a friend asked my opinion on how long I thought his wife could be expected to live, this because of the fact that he could not justify in his own mind the necessary expenditure to remodel his home if his only companion had just one or two years to live. Her heart was markedly enlarged, her blood pressure was recorded at 260+/120 and her mental processes had been badly affected; the prognosis was poor. This was ten years ago and the patient is still alive. Her husband, a fine physical specimen who played several sets of tennis each week, died six years ago of myocardial infarction.

The daughter and only child of a wealthy contractor had several skin lesions removed soon after the birth of her first child. Three of these were diagnosed as malignant melanoma by a competent pathologist. The patient's father literally "went to pieces" upon learning of the diagnosis and poor prognosis, the latter at least partly being based upon the finding of metastatic tumor in one axillary lymph node. This was six years ago. The patient is alive and apparently well; her father has become an alcoholic and has had several episodes of delirium tremens.

Many more and various similar examples could be cited, but space does not permit a more lengthy presentation. The literature and unrecorded experiences of physicians all over the world are replete with many such cases. Apart from these there are ill-defined disease complexes which in their manifestations present themselves much the same as the psychopathic condensations now masquerading under the guise of modern art. And, while there can be no question but that the science of medicine will advance our understanding of basic disease processes far beyond many expectations, there will always remain intangible and immeasurable physical and biochemical "oddities" which will tend to play havoc with our peace of mind.

Charles Catanzaro, M.D.
The Bulletin
Hillsborough County Medical Association
December 1959.

BLUE SHIELD

Big Oaks From Little Acorns

Overutilization. Unnecessary hospitalization. Overemphasis, chorus many doctors and hospital administrators, but to the public it is an abuse which is one of the major causes of skyrocketing hospital costs, with the resultant increase in Blue Cross rates.

The extent of unnecessary hospitalization and its effect on hospital costs are difficult to determine because of lack of dependable information and the conflicting interpretations placed on the limited studies which have been conducted. One of the most comprehensive surveys to date, that by the Citizens Hospital Study Committee of Northeast Ohio (Cleveland), indicates that if any overutilization exists, it is an exceedingly small percentage of the total. A survey in Pennsylvania, under the sponsorship of State Insurance Commissioner Francis R. Smith, does not agree with this finding, at least in the opinion of Commissioner Smith. Be that as it may, how expensive is even a small amount of unnecessary hospitalization in terms of 47 cent dollars?

The average cost in 1959 of keeping a patient in a Florida hospital for one day was $30.41, which includes all charges for services and supplies, not merely room and board. In Florida there are over 4,000 Blue Shield participating physicians. If just one half of these physicians permit one excess day of hospital care for one patient, the daily cost amounts to $60,820. Should

this same situation prevail throughout an entire year, the total cost reaches a staggering $22,199,300. This is almost as much as Florida Blue Shield and Blue Cross together paid in subscriber benefits in 1959. It is 20 per cent more than Blue Cross alone paid, and nearly three times that expended by Blue Shield last year.

It may well be that it is unrealistic to assume that 50 per cent of all participating physicians will be so careless about hospital admissions and discharges. Let us assume that the number of doctors who fall into this category is no more than 200, a mere 5 per cent of the total; the excess cost still adds up to over $2,000,000. Even in inflated dollars that is not exactly small change.

It is accepted that it is the right and duty of the attending physician to determine whether a patient should be hospitalized, when he should be admitted and when discharged. It must equally be accepted that patients are hospitalized who could readily have received adequate care elsewhere. Then, too, it is not entirely unknown to find instances of extra days added here and there through conscientious physicians admitting patients earlier than required, or delaying to discharge them at the earliest date consistent with sound medical judgment.

Every little bit added to the little bit we have always makes a little bit more. Isolated cases of overutilization of hospitals seem insignificant until weighed in the balance with hundreds of similar cases throughout the state and nation. Let us again remind ourselves that those who pay today's high hospital bills, either directly or through some form of prepaid protection, are greatly concerned. Effective corrective measures by the medical profession at this time will do much to forestall an aroused public from demanding relief from a paternalistic government.

STATE NEWS ITEMS

Dr. Louis M. Orr of Orlando, President of the American Medical Association, was featured speaker at a joint meeting of the Chancellors and Councilors of the American College of Radiology and the Louisiana Radiological Society held in New Orleans February 4.

Dr. Jere W. Annis of Lakeland, immediate Past President of the Florida Medical Association, was principal speaker at the Public Education Conference, District 7, American Cancer Society, held January 14 at the Lakeland Civic Center in Lakeland. On January 15, Dr. Annis addressed members of the Haines City Rotary Club at Haines City. His subject was heart disease.

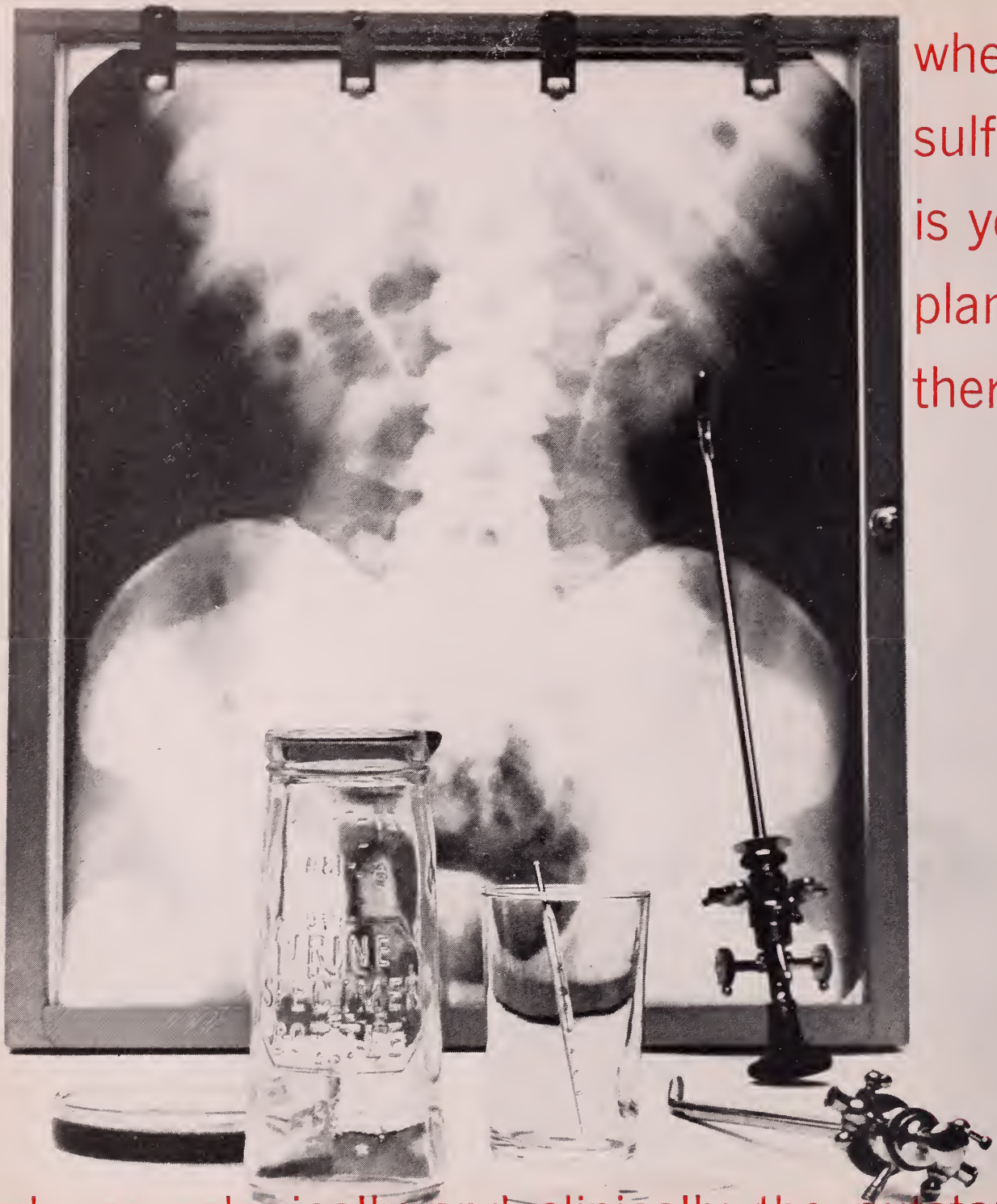
Dr. DeWitt C. Daughtry of Miami has been elected first vice president of the Southern Chapter of the American College of Chest Physicians.

A $25,000 two year grant for the establishment of an alcoholic research and treatment unit at the Teaching Hospital and Clinics has been received by the College of Medicine, University of Florida, from the Florida Alcoholic Rehabilitation Program.

Dr. Thomas M. Edwards of Tampa has been elected chairman of the Florida Gulf Coast ENT Society, and Dr. Milton R. Himalstein of Bay Pines has been chosen as secretary-treasurer. At the first meeting of the group on November 7, 11 members presented problem cases for discussion. They included Drs. Richard A. Bagby, J. Brown Farrior, Richard T. Farrior, Maurice Haddad, Robert L. Levine and Dr. Edwards of Tampa; Drs. Albert J. Davis Jr., and Chester L. Goodnow of St. Petersburg; Dr. Warren C. Evans of Gainesville; Dr. George H. Schoetker of Clearwater, and Dr. Himalstein of Bay Pines.

The Eighth Congress of the Pan-Pacific Surgical Association is scheduled for September 27-October 5 in Honolulu, Hawaii. Information may be obtained from Dr. F. J. Pinkerton, Director-General, Suite 230, Alexander Young Bldg., Honolulu 13, Hawaii.

The Thirty-Third Annual Spring Congress in ophthalmology, otology, rhinology, laryngoscopy,



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1. Boger, W. P.; Strickland, C. S., and Gylfe, J. M.: Antibiotic Med. & Clin. Ther. 3:378, (Nov.) 1956. 2. Boger, W. P.: Antibiotics Annual 1958-1959, New York, Medical Encyclopedia, Inc., 1959, p. 48. 3. Sheth, U. K.; Kulkarni, B. S., and Kamath, P. G.: Antibiotic Med. & Clin. Ther. 5:604 (Oct.) 1958. 4. Vinnicombe, J.: Ibid. 5:474 (July) 1958. 5. Anderson, P. C., and Wissinger, H. A.: U. S. Armed Forces M. J. 10:1051 (Sept.) 1959. 6. Roepke, R. R.; Maren, T. H., and Mayer, E.: Ann. New York Acad. Sc. 60:457 (Oct.) 1957.

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maxillofacial surgery, bronchoscopy and esophagoscopy of the Gill Memorial Eye, Ear and Throat Hospital and The Elbyrne G. Gill Eye and Ear Foundation will be held April 4-9 at Roanoke, Va.

The University of Miami School of Medicine is dedicating its new research building March 3 in ceremonies at the Medical Center in Miami. Dr. Robert B. Lawson, Professor and Chairman of the Department of Pediatrics, is general chairman for the dedication program.

The Fourth Post-Graduate Course on Fractures and Other Trauma, sponsored by the Chicago Committee on Trauma of the American College of Surgeons, will be held April 27-30 at the John B. Murphy Memorial Auditorium in Chicago.

The annual meeting of the West Virginia Academy of Ophthalmology and Otolaryngology is being held on April 10-12 at the Greenbrier Hotel, White Sulphur Springs, W. Va. Information on the meeting may be obtained from Dr. Albert C. Esposito, First Huntington National Bank Bldg., Huntington 1, W. Va.

A postgraduate seminar in arthritis and related diseases will be held June 11-12 in the Diplomat Hotel at Hollywood, Fla. Sponsoring organizations include the Florida Chapter of the Arthritis and Rheumatism Foundation; University of Miami School of Medicine; College of Medicine, University of Florida, and the South Florida Rheumatism Society.

A course in otology and maxillofacial surgery is being presented Wednesday, Thursday and Friday, March 9-11, in Tampa by Drs. Richard T. Farrior and J. Brown Farrior. Lectures, beginning at 8:30 a.m., will be presented in the Conference Room of Tampa General Hospital, and the study and discussion of scientific exhibits will take place at the Southern Foundation.

The 46th Annual Clinical Congress of the American College of Surgeons has been scheduled for October 10-14, 1960, in San Francisco. Information may be obtained from Dr. William E. Adams, Secretary, 40 East Erie St., Chicago 11, Ill.

Dr. Eugene D. Liddy Jr. of Sarasota discussed heart disease at a recent regular meeting of the M. Aurel Rosin Lodge, B'nai B'rith, held in Sarasota.

Drs. F. Hardy Bowen, Samuel M. Day and Wilbur C. Sumner of Jacksonville were among the group of physicians from Florida attending the recent annual meeting of the Southern Surgical Association held at Hot Springs, Va.

Dr. Carlos P. Lamar of Miami was guest speaker at the January meeting of the Greater Miami Lay Diabetes Society. The subject of his address was "General Facts in Diabetes."

Dr. Theodore C. Keramidas of Winter Haven discussed the Hippocratic Oath and its pertinence to the motivation of medical missions at a recent chapel service of the Beymer Memorial Methodist Church of Winter Haven.

Dr. William C. Roberts of Panama City, a Past President of the Florida Medical Association, was principal speaker at the mid-January annual education conference of District Three, Florida Division of the American Cancer Society, held at Tallahassee.

Dr. Franklin J. Evans of Coral Gables presented a paper entitled "New Drugs in Medical Practice: Onus of Experimentation as a Medico-Legal Hazard" at the 12th annual meeting of the American Academy of Forensic Sciences held at Chicago early in March.

Dr. John J. Fisher of Jacksonville was principal speaker at a recent meeting of the Arlington Woman's Club of that city. His subject was cancer and the importance of regular physical examinations.

Dr. Andre S. Capi of Hollywood has been elected president of the Greater Miami Radiological Society. Dr. George P. Daurelle of Miami will serve as vice president, and Dr. Donald H. Altman of Miami as secretary-treasurer.

The Sixth Annual Central Florida Medical Meeting in Orlando March 12 will be held in the Cherry Plaza Hotel instead of the San Juan Hotel.

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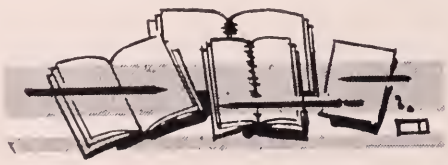
Medical Licenses Granted

Dr. Homer L. Pearson Jr., secretary of the State Board of Medical Examiners, has reported that of the 266 applicants who took the examination of the Board, held November 21-22, 1959, in Miami Beach, 211 passed and have been issued licenses to practice medicine in Florida. The names and addresses of the 211 successful applicants follow:

Adler, Richard Charles, Miami Beach (Vanderbilt 1959)
Agnew, John Richard, Denver (Georgetown 1959)
Agnone, Eugene John, Miami (Hahnemann 1944)
Alexiou, Nicholas George, Jacksonville (U. Vermont 1955)
Allen, Frederick Kay, Bradenton (Indiana U. 1941)
Amer, Norman Stanley, Valley Stream, N. Y. (Jefferson 1954)
Anlyan, Frederick Henry, Norwood, Mass. (Boston U. 1959)
Antelis, Eugene, Brooklyn (Cornell 1954)
Applebaum, Robert Myron, Miami (St. Louis U. 1957)
Arman, Ata, Fort Stewart, Ga. (Tehran U. 1942)
Barr, Samuel Jacob, Miami (Jefferson 1959)
Beber, Bernard Arthur, Miami (U. Nebraska 1957)
Beck, Morris, Miami (U. Zurich 1957)
Becker, Melvin Harry, New York (Washington U. 1950)
Bederman, Stuart Stanley, Glenview, Ill. (U. Illinois 1945)
Berlien, Ivan Clark, Detroit (Wayne U. 1937)
Birndorf, Raymond Lawrence, Chicago (U. Chicago 1953)
Blanton, Russell Perry, Cross City (Emory U. 1958)
Bloch, Malcolm Henry, Jersey City, N. J. (St. U. N. Y. 1956)
Boudreau, Robert Francis, Galveston, Tex. (U. Ottawa 1952)
Brackney, Edwin Leland, Augusta, Ga. (U. Minnesota 1947)
Brandt, Ralph Lee, Ann Arbor, Mich. (U. Michigan 1953)
Brashear, Richard Evers, San Francisco (Ohio St. U. 1958)
Brewer, Harold David, Tampa (U. Mississippi 1958)
Brewster, William Russell Jr., Gainesville (Columbia U. 1946)
Brock, Derek Powell, Albany, Ga. (Louisiana St. U. 1957)
Brosman, Stanley Allan, Miami (Indiana U. 1959)
Bryan, William Blair, Jacksonville (Duke U. 1956)
Burstiner, Jack Martin, New York (St. Louis U. 1954)
Cahill, Charles Adams, III, Tampa (Harvard 1955)
Carroll, William Jerome, Orlando (Jefferson 1959)
Carter, Randolph Laurie Jr., DeLand (Emory U. 1959)
Casey, James Francis, Forest Hills, N. Y. (Columbia 1956)
Cassady, Richard Lee, North Miami (Indiana U. 1959)
Cherkas, Marshall Seymour, South Miami (Northwestern 1959)
Cheshire, McKinley Jr., DeFuniak Springs (Duke U. 1958)
Cohen, Clarence L., Jamaica, N. Y. (U. Munich 1958)
Cohn, Lee Stern, New Orleans (U. Wisconsin 1956)
Conovitz, Myron William, Brookline, Mass. (Harvard 1958)
Conti, Robert Ferdinand, Miami (Loyola U. 1955)
Cox, Jerry Frank, North Miami (Indiana U. 1959)
Crowder, John Ingalls, Miami (Stanford U. 1958)
Dakos, William Nicholas, Birmingham, Ala. (U. Virginia 1956)
Daly, William Michael, Miami (Alabama 1959)
David, Theodore Arthur, Philadelphia (Temple U. 1950)
Des Jean, Paul Arthur, Indianapolis (Indiana U. 1942)
Dobrak, Alfred Harris, Fort Lauderdale (U. Buffalo 1939)
Down, Russell Joseph II, Tampa (Hahnemann 1959)
Dummit, Garland Derond, Tampa (U. Louisville 1958)
Eagan, John Thomas, Durham, N. C. (Johns Hopkins 1953)
Earnhart, William Russell, Hialeah (Indiana U. 1959)
Edelstein, Leon Melvin, Miami (U. So. Calif. 1959)
Egan, John Wallace, Miami (St. U. N. Y. 1954)
Egolf, Robert Lewis, Miami (Temple U. 1959)
Eller, William Crawford, Waterloo, Iowa (U. Colorado 1940)
Enneking, William Fisher, Gainesville (U. Wisconsin 1949)
Escamilla, Jorge Octavio, Milledgeville, Ga. (Natl. U. Colombia 1950)
Fastenberg, Milton, New York (U. Geneva 1936)
Fearnow, Ronald Grayson, Tampa (Virginia 1959)
Feldman, Ronald, North Miami Beach (Columbia 1956)
Fening, Walter Edward, Middletown, Ohio (U. Cincinnati 1944)
Ferayorni, Julius Joseph, Brooklyn (N. Y. M. C.-Flower Hosp. 1931)
Ferguson, Emmett Bonlore Jr., Orlando (U. Oklahoma 1959)
Finley, Bernard Lowell, Miami (U. California 1959)
Floyd, Waldo Emerson Jr., Charleston, S. C. (Johns Hopkins 1954)

EIGHTY-SIXTH Annual Meeting
FLORIDA MEDICAL ASSOCIATION
April 8-11, 1960



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Ford, John Hevener Jr., Miami (U. Pennsylvania 1959)
Frankel, Nathanel Ralph, Columbia, S. C. (New York U. 1957)
Freeman, Alfred, Glenside, Pa. (Temple U. 1953)
Frerichs, Cletus Troy, Beatrice, Neb. (U. Nebraska 1947)
Friedman, Stuart Joel, West Orange, N. J. (Chicago 1959)
Friend, Arthur, Arcadia (St. Louis U. 1935)
Gardner, William James, Ridgefield, Wash. (Coll. Med. Evan. 1944)
Ginsberg, George, Miami (Columbia U. 1959)
Glasner, Saul, Miami (Jefferson 1959)
Glick, Henry Irwin, Miami (Indiana U. 1959)
Goldstein, Harold Solomon, Miami (St. U. N. Y. 1956)
Goldstein, Louis Marshall, Miami Beach (Jefferson 1959)
Gravenstein, Joachin Stefan, Gainesville (Harvard and U. Bonn 1951)
Gross, Edward F., Coral Gables (Vanderbilt 1958)
Grossman, Alan Richard, Miami Beach (U. Tennessee 1957)
Grossnickle, James Walter, Winter Haven (Northwestern 1951)
Grover, Frederick Wilson, Dallas, Tex. (U. Ottawa 1953)
Haynes, Columbus Doyle, Atlanta, Ga. (Emory U. 1959)
Heard, Milton Gilbert, Miami (U. Miami 1958)
Hefner, James Donald, Ocala (Vanderbilt 1955)
Heineman, Arthur Charles Jr., Pittsburgh (U. Pittsburgh 1952)
Helfman, Richard Joel, Eglin AFB (Chicago 1956)
Hiatt, Robert Andrew, Fairview, Mass. (Western Reserve 1954)
Hirsch, Stanley Allan, Brookline, Mass. (U. Pittsburgh 1959)
Hoffner, Herbert Howard, Arverne, N. Y. (Tufts U. 1959)
Holmes, Thomas Graham, St. Louis, Mo. (Alabama 1957)
Honig, James, Miami Beach (Northwestern 1958)
Hortenstine, Clarence Bernard, Bayside N. Y. (Virginia 1955)
Huntsinger, Larry Alan, Miami (Indiana U. 1959)
Hutcheson, James Byron, Tampa (Virginia 1946)
Hyden, William Hieronymus, Lexington, Ky. (U. Louisville 1940)
Ivory, Harry Stauderman, Largo (Hahnemann 1928)
Jackson, Joseph Hoyt Jr., Gainesville (Duke U. 1956)
Jackson, Royce Van, Daytona Beach (Georgia 1958)
Jahnig, Paul William, West Palm Beach (U. Miami 1959)
Jelks, Mary Larson, Gainesville (U. Nebraska 1955)
Jernigan, James Austin, Washington, D. C. (Washington U. 1949)
Johnson, James Henry, Durham, N. C. (Virginia 1954)
Jones, Robert Holmes, Miami (Columbia 1959)
Juliano, Aniello Anthony, Ft. Lauderdale (Loyola U. 1932)
Jurkiewicz, Maurice John, Gainesville (Harvard 1952)
Kahana, Shirley Elizabeth, Tampa (Washington 1953)
Kahn, Alexander Jerome, Indianapolis (Indiana U. 1942)
Kaminsky, Aaron Louis, Miami Beach (U. Maryland 1935)
Kaufmann, Maurice, Ft. Lauderdale (U. Louisville 1935)

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Kelleher, David Francis, Lansdowne, Pa. (Hahnemann M. C. 1953)
Kellert, Albert Jerome, Yonkers, N. Y. (N. Y. M. C. Flower & 5th Hosp., 1954)
Kinder, Robert Samuel Lufbery, Miami (George Washington U. 1959)
King, Jerald Paul, San Antonio, Texas (U. Tennessee 1957)
Kirby, Taylor Herman Jr., Washington, D. C. (George Washington U. 1953)
Kissam, Edward Bernard, Augusta, Ga. (Bowman Gray 1955)
Knight, Theron Turner Jr., Miami (U. Louisville 1959)
Korman, Norman Ritt, Miami (U. Berne 1953)
Kuvin, Sanford Fleishfarb, Boston (Cambridge U. 1957)
La Camera, Frank Jr., East Cleveland, Ohio (U. Cinn. 1953)
Lach, Frank Edward, Woodbridge, Conn. (U. Maryland 1941)
Lansford, Frederick Duke Jr., Chattanooga, Tenn. (U. Tenn. 1956)
Laughlin, Majorie Ann, Decatur, Ga. (Georgetown U. 1959)
Laughlin, Theodore Daniel, Decatur, Ga. (Georgetown U. 1959)
Lennox, Kenneth Walter, West Hollywood (N. Y. M. C. 1959)
Levenson, Arthur, North Miami Beach (Temple U. 1931)
Liebeskind, Robert Sheldon, Miami (M. C. Ala. 1959)
Lodge, Elizabeth Masefield, McMinnville, Tenn. (U. Tenn. 1957)
London, Frederick Allan, Miami (Columbia U. 1959)
Long, Edwin Tutt, Hinsdale, Ill. (Columbia U. 1947)
Macy, George Webster, Columbus, Ind. (Indiana U. 1935)
Mare, Alan, Miami (Cornell U. 1959)
Martinez, Victor Julio, Miami (U. Miami 1959)
Maticka, Jack Barney, Peoria, Ill. (M. C. Ala. 1950)
Maxwell, Richard Wayne, Tampa (Indiana U. 1959)
McClanahan, Berry Judson, Hornell, N. Y. (M. C. Virginia 1947)
McCollough, Newton Clark III, Miami (U. Penna. 1959)
McCuiston, Claude Frederick, Jacksonville (Emory U. 1954)
McPherson, Alice Ruth, Temple, Texas (U. Wisc. 1951)
McPherson, Herbert Allen Jr., Ashdown, Ark. (Louisiana St. U. 1956)
Metts, Vergil Leonard III, Flomaton, Ala. (M. C. Ala. 1956)
Meyers, Richard Milford, Flushing, N. Y. (St. U. N. Y. 1956)
Minckler, Tate Muldown, Miami (U. Oregon 1959)
Molinet, Roland Kenesaw, West Palm Beach (N. Y. M. C. 1959)
Moore, Dean Crawford, Orange, N. J. (Cornell U. 1922)
Neale, Richard Carroll Jr., Tampa (M. C. Va. 1959)
Nealy, Robert John, Columbus, Ga. (Emory U. 1959)
Newcomb, Thomas Finley, Gainesville (U. Pittsburgh 1951)
Nichols, John, Kansas City, Kan. (Royal Col. Phy. & Surg.-Edinburgh 1954)
Nieman, Harry Abraham, Dayton, Ohio (Ohio St. U. 1936)
Nunn, Daniel Brunson, Charleston, S. C. (M. C. S. C. 1955)
Oper, Arnold Abbott, Chandler, Ariz. (St. U. N. Y. 1957)
Palmer, Robert Hamilton Jr., Pensacola (Tulane U. 1949)
Palumbo, Pasquale, Coral Gables (U. Bologna 1957)
Pappas, Paul Nick, East Cleveland, Ohio (Indiana U. 1958)
Paston, Philip, Miami Beach (U. Geneva 1958)
Paulsen, Suzanne Margaret, Miami (U. Washington 1959)
Peacock, Howard Kenneth Jr., Camp LeJeune, N. C. (Albany M. C. 1951)
Pellicane, Anthony Joseph Jr., South Miami (Jefferson M. C. 1958)
Pittell, Robert Seymour, Jacksonville (U. Buffalo 1955)
Prystowsky, Harry, Gainesville (M. C. S. Carolina 1948)
Puschett, Jules Bernard, Miami (U. Penna. 1959)

Rawl, Jasper Franklin Jr., Charleston, S. C. (M. C. S. C. 1954)
Reeder, James Lendon, Fernandina Beach (M. C. Ala. 1955)
Rekant, Joseph, Miami Beach (Long Island C. M. 1935)
Retterbush, William Charles, Valdosta, Ga. (Ohio St. U. 1947)
Rivera, Rolando Jesus, Miami (U. Havana 1950)
Robb, George William, Margate, New Jersey (Hahnemann M. C. 1959)
Robbins, Thomas Waters Jr., Haddonfield, New Jersey (Duke U. 1959)
Roberts, George Albert, Austin, Minn. (U. Illinois 1944)
Robertson, Dudley Skinner Jr., Raleigh, N. C. (M. C. Va. 1959)
Roda, James Joseph, Garfield Hts., Ohio (Ohio St. U. 1957)
Ross, Harvey Myron, St. Petersburg (Emory U. 1954)
Ruderman, Joseph Edmund, Miami (Hahnemann M. C. 1959)
Sams, Wiley Mitchell Jr., Atlanta, Ga. (Emory U. 1959)
Sarmiento, Augusto, Miami (Nat'l U. Colombia 1952)
Sayers, James Rolland, Palatka (U. Okla. 1929)
Sayre, Malcolm Maynard, Orlando (M. C. Georgia 1959)
Schick, Alfred, Charlotte, N. C. (U. Rochester 1950)
Schlanger, Warren William, Miami Beach (Chicago M.S. 1959)
Schorr, William Francis, Miami (Marquette U. 1957)
Schwab, John Joseph, Gainesville (U. Louisville 1946)
Schwenker, Carl Emerson Jr., Miami (U. Cinn. 1959)
Sciscent, Verdi Italo, Ft. Lauderdale (George Washington U. 1946)
Selfman, David, Miami (Ohio St. U. 1959)
Shear, Carol Schwartz, Miami (Womans M. C.-Penna. 1957)
Shilen, Thomas Sevier, Miami (Jefferson M. C. 1959)
Shipman, William Franklin Jr., New Orleans (M. C. Georgia 1954)
Sidwell, Walter Frank, Milton (U. Tenn. 1955)
Silverstein, Bernard Stanley, Ann Arbor, Mich. (M. C. N. Y. 1953)
Smouse, William Reed, New Orleans (M. C. Va. 1955)
Spertus, Irving, Brooklyn (U. Geneva 1956)
Spielman, Stanley Leon, Miami Beach (Jefferson M. C. 1959)
Stark, Thomas Hall, Orlando (M. C. Va. 1957)
Statman, Norman Marvin, Miami Beach (U. Cinn. 1957)
Stein, Samuel Joseph, Newark, N. J. (Chicago M.S. 1959)
Sternberg, Martin Stephen, Miami (St. U. N. Y. 1957)
Stevens, Ned Stanley, West Palm Beach (Ohio St. U. 1959)
Sutton, Elbert Wavera, Mobile, Ala. (Tulane U. 1958)
Tobis, Alvin Eugene, St. Petersburg (St. U. N. Y. 1955)
Traverse, Norman, Boston (U. Tenn. 1957)
Tresser, Melvin, Selma, Ala. (N. Y. U. 1956)
Trotter, George Sedding, Jacksonville (U. Maryland 1959)
Tylar, Norman Eric, Tampa (Georgetown U. 1932)
Weiner, Donald Mason, Miami Beach (U. Berne 1958)
White, Alvyn Waverly Jr., Pensacola (Duke U. 1958)
Willard, Mary Flynn, Orlando (Tulane U. 1955)
Woody, Ronald Harlan Jr., Jacksonville (George Washington U. 1957)
Wunsch, Jayne Hardy, Miami (U. Texas 1959)
Young, Betty May, Bradenton (U. Vermont 1959)
Zwiren, Gerald Theodore, Richmond, Va. (M. C. Va. 1954)

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OBITUARIES

John Erwin Gottsch

Dr. John Erwin Gottsch of Tampa met accidental death when felled by a bolt of lightning on Sept. 9, 1959, while seeking shelter from a rain storm on the golf course of the Palma Ceia Country Club in that city. He was 36 years of age.

Dr. Gottsch was born on Sept. 23, 1923 in Shenandoah, Iowa. He received his medical training at the State University of Iowa College of Medicine and was awarded the degree of Doctor of Medicine by that institution in 1947. After completing an internship at Charity Hospital in New Orleans, he returned to his alma mater for a year's postgraduate study in orthopedic surgery. He then held an orthopedic residency at Charity Hospital from 1949 to 1951. From 1952 to 1954 he served at the MacDill Air Force Base Hospital in Tampa and upon completion of military service he became associated with Drs. Frank H. Lindeman Jr. and Ulysses A. Young of Tampa in the practice of orthopedic surgery. His medical fraternity was Nu Sigma Nu.

Dr. Gottsch was a member of the Hillsborough County Medical Association and since 1955 had held membership in the Florida Medical Association. He was also a member of the American Medical Association and a fellow of the American College of Surgeons. He was certified by the American Board of Orthopaedic Surgery and was

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a member of the American Academy of Orthopaedic Surgery.

Surviving are the widow, Mrs. Rachel Gottsch, and four children. His parents, Dr. and Mrs. Erwin J. Gottsch, of Shenandoah, Iowa, also survive.

Benjamin Franklin Barnes

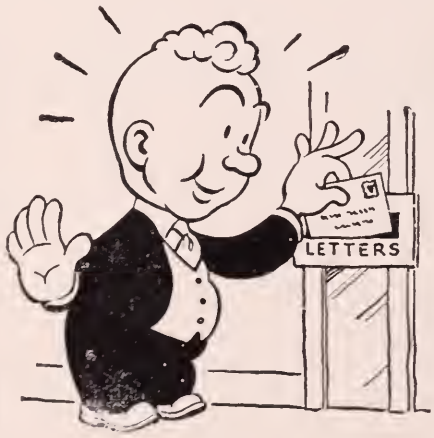
Dr. Benjamin Franklin Barnes of Chattahoochee died on Sept. 11, 1959, at the Frazier Ellis Hospital in Dothan, Ala. He was 82 years of age. Interment took place at the Mt. Pleasant Cemetery in Chattahoochee.

A native Floridian, Dr. Barnes was born in Jefferson County, near Monticello, on Feb. 28, 1877. He received his academic training at the South Florida Military and Educational Institute, where he was graduated in May 1897. For his medical education he attended the University of Pennsylvania for two years, the University of Maryland for one year and Marion Sims College of Medicine in St. Louis for the final year, receiving the degree of Doctor of Medicine there in 1901.

That same year, Dr. Barnes entered the private practice of medicine in Monticello. Two years later, he located in Chattahoochee, where he spent 56 years of unselfish and devoted service to the people of Chattahoochee and the surrounding area in the general practice of medicine. In ill health in recent years, he nevertheless continued to practice until November 1958. In February 1953, the community honored Dr. Barnes in special ceremonies commemorating his 50 years of service in the practice of medicine in the area. At that time his many civic, fraternal, school and town activities were also stressed. He was instrumental in getting the city incorporated in 1921, became its first elected mayor and served in that capacity for 18 years. For 32 years he served as a school trustee. In 1905 he became a member of the Gee Lodge F&AM, No. 21, and served continuously as its secretary for 45 years. In 1907 he became a Shriner. A member of the local Rotary Club, he also served faithfully in the Chamber of Commerce through the years. This pioneer general practitioner was the first to operate a drug store in Chattahoochee and also the first resident to talk over the telephone.

Dr. Barnes was a member of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical

(Continued on page 1163)



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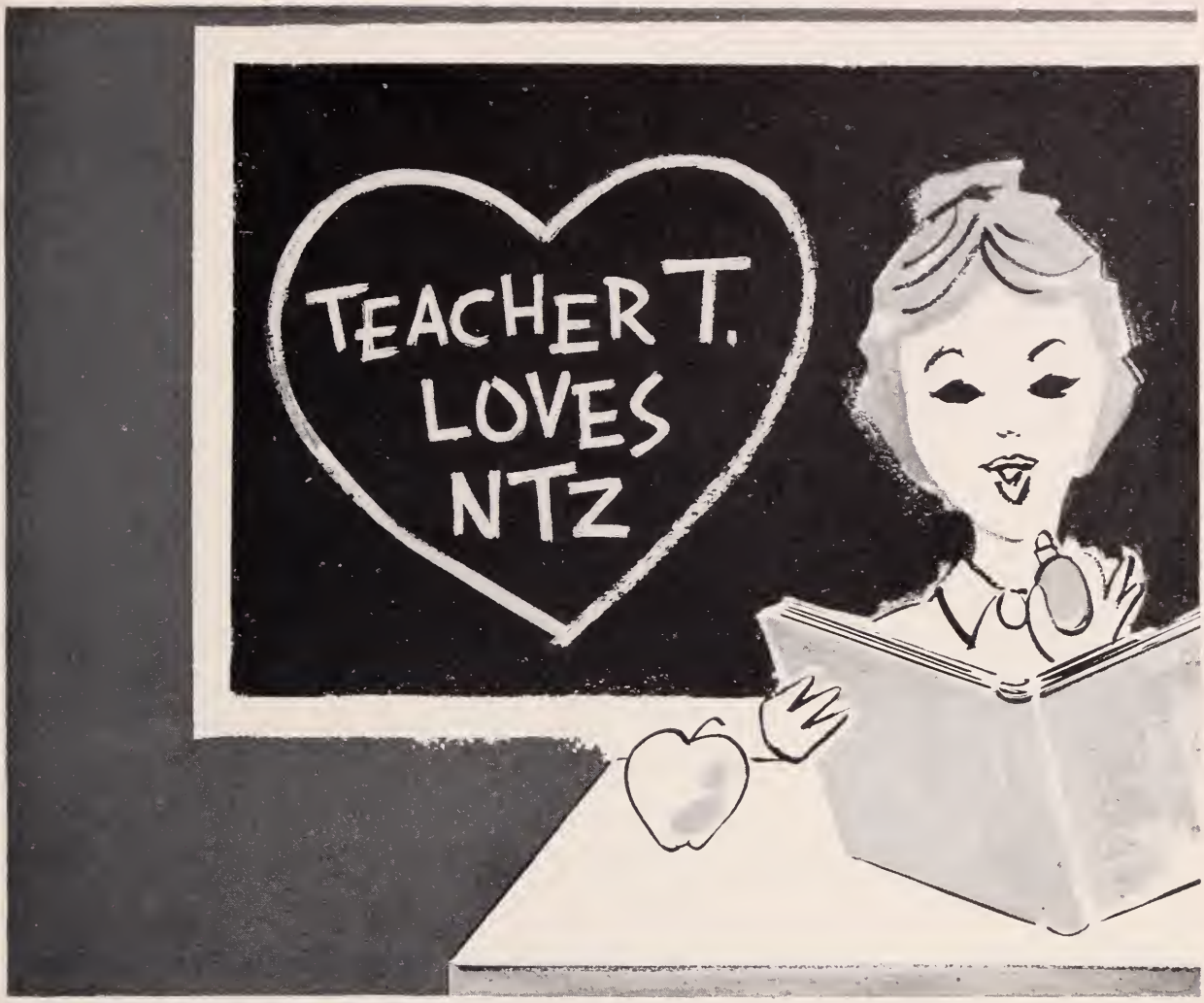

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the lasting relief from colds
puts NTZ Nasal Spray
in a class by itself.**

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*20 cc. spray bottles;
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Neo-Synephrine® HCl, 0.5%
—unexcelled decongestant—

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- Each Geroniazol TT tablet contains:
  Pentylenetetrazol .....300 mg.
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Patent #2748052

for medical management of obesity

The **different** amphetamine combination of choice... even in many cases of hyperthyroidism, hypertension, coronary artery and other cardiovascular diseases.

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OBETROL incorporates the desired action of amphetamines without usual drawbacks.

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SUPPLIED: in 10 mg. and 20 mg. tablets in bottles of 100, 500, and 1,000.

Ref: Plotz, M.: Modern Management of Obesity, J.A.M.A. 170: 1513-1515 (July 25) 1959.

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Page 753 REFER TO PDR

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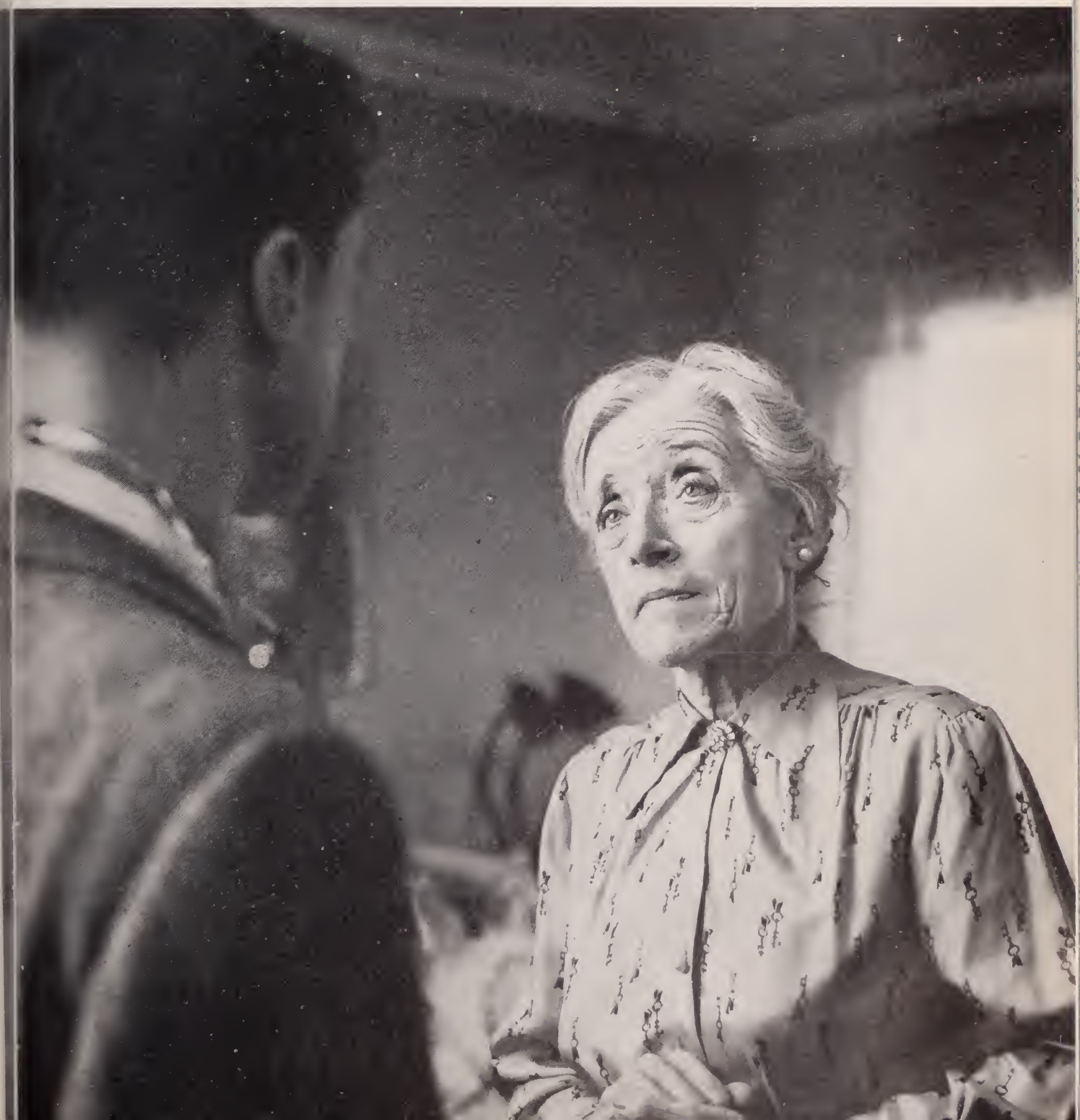

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IN *ORAL* CONTROL OF PAIN

ACTS FASTER—usually within 5-15 minutes. **LASTS LONGER**—usually 6 hours or more. **MORE THOROUGH RELIEF**—permits uninterrupted sleep through the night. **RARELY CONSTIPATES**—excellent for chronic or bedridden patients.

AVERAGE ADULT DOSE: 1 tablet every 6 hours. May be habit-forming. Federal law permits oral prescription.

Each PERCODAN* Tablet contains 4.50 mg. dihydrohydroxycodeinone hydrochloride, 0.38 mg. dihydrohydroxycodeinone terephthalate, 0.38 mg. homatropine terephthalate, 224 mg. acetylsalicylic acid, 160 mg. phenacetin, and 32 mg. caffeine.

Also available — for greater flexibility in dosage — PERCODAN®-DEMI: The PERCODAN formula with one-half the amount of salts of dihydrohydroxycodeinone and homatropine.

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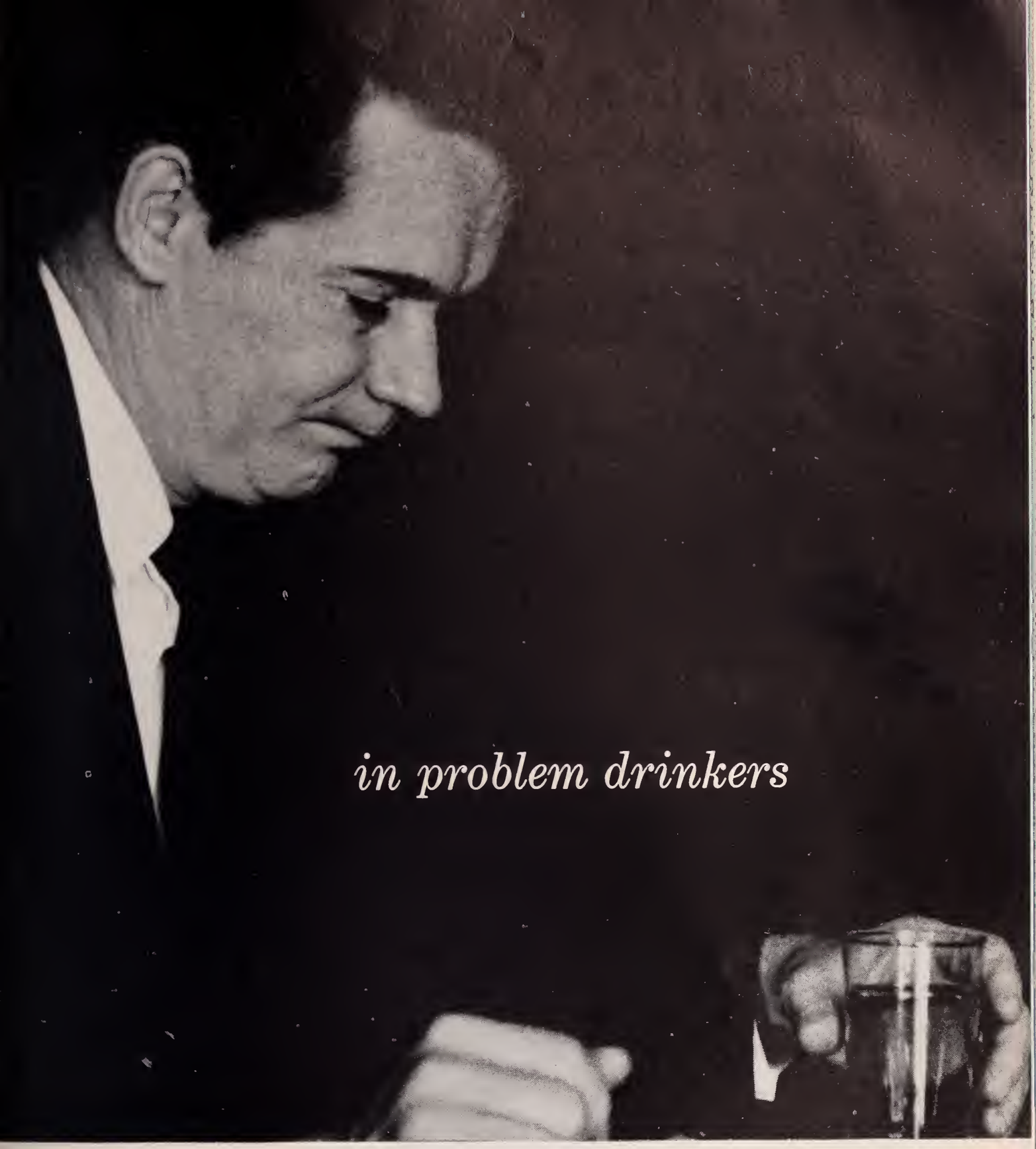
Percodan® *Tablets*

Salts of Dihydrohydroxycodeinone and Homatropine, plus APC

FOR PAIN

*U.S. Pat. 2,628,185



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hydroxyzine pamoate

dispels tension...
maintains tranquility

When tension and anxiety "drive him to drink," the problem drinker often finds that VISTARIL, by maintaining tranquility, restores perspective and helps him accept counsel more readily.

VISTARIL has demonstrated a wide margin of safety even in large doses (300-400 mg. daily) over prolonged periods. Clinical studies of alcoholism have shown that VISTARIL produces no significant depression of blood pressure, pulse rate, or respiration in chronic drinkers.

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Raise the Pain Threshold

WITH MAXIMUM SAFE ANALGESIA

Phenaphen with Codeine provides intensified codeine effects with control of adverse reactions. It renders unnecessary (or postpones) the use of morphine or addicting synthetic narcotics, even in many cases of late cancer.

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Phenaphen with Codeine Phosphate ¼ gr. (16.2 mg.)

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Also —

PHENAPHEN In each capsule

Acetylsalicylic Acid 2½ gr. .	(162 mg.)
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Phenobarbital ¼ gr.	(16.2 mg.)
Hyoscyamine sulfate	(0.031 mg.)

PHENAPHEN® WITH CODEINE

Robins

Robins

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Ethical Pharmaceuticals of Merit since 1878

Butazolidin®
brand of phenylbutazone

in arthritis and allied disorders

proved by a decade of experience

Ten years of experience in countless cases—more than 1700 published reports—have now established the eminence of Butazolidin among the potent non-hormonal antiarthritic agents.

Repeatedly it has been demonstrated that Butazolidin:
Within 24 to 72 hours produces striking relief of pain.
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Butazolidin® brand of phenylbutazone: Red-coated tablets of 100 mg.
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Just one prescription for Engran Term-Pak
SQUIBB VITAMIN-MINERAL SUPPLEMENT *(270 tablets)*
calling for just one tablet per day will carry her through term to the six-week postpartum check-up. Thus, you help to assure a nutritionally perfect pregnancy, while providing the convenience and economy of the re-usable Term-Pak. Engran is also available in bottles of 100 tablets.

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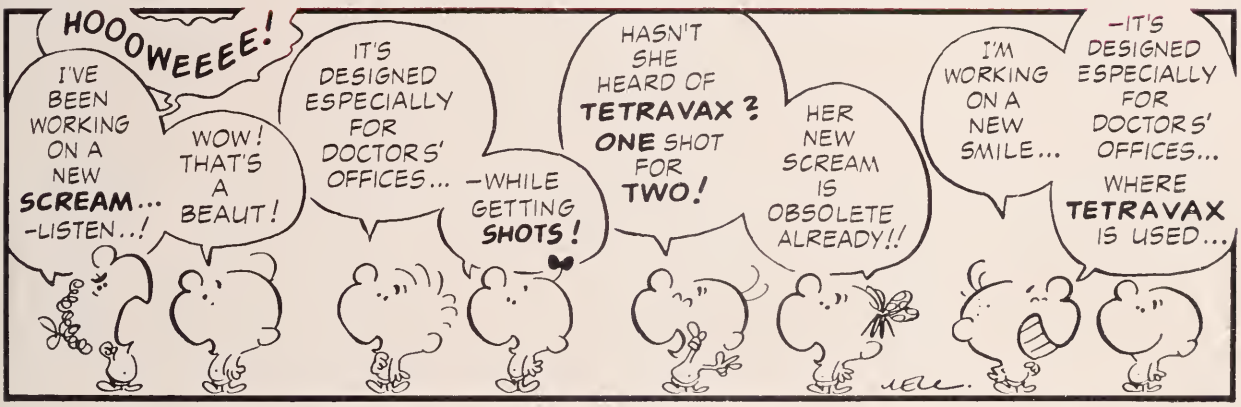

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DIPHTHERIA AND TETANUS TOXOIDS WITH PERTUSSIS AND POLIOMYELITIS VACCINES

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Dose: 1 cc.
Supplied: 9 cc. vials in *clear plastic* cartons. Package circular and material in vial can be examined without damaging carton. Expiration date is on vial for checking even if carton is discarded.

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Each of the babies pictured on this page was borne by a mother with a *documented* previous history of true habitual abortion, who was treated with DELALUTIN during the pregnancy leading to this birth

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SQUIBB HYDROXYPROGESTERONE CAPROATE

Improved Progestational Therapy

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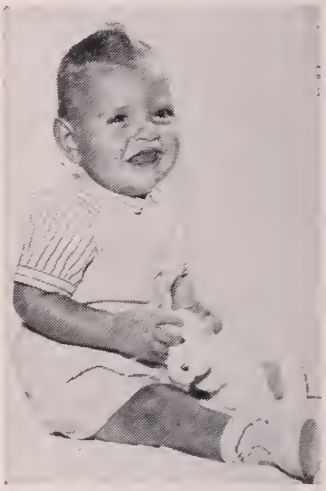

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DELALUTIN offers these advantages over other progestational agents

• long-acting sustained therapy • more effective in producing and maintaining a completely matured secretory endometrium • no androgenic effect • more concentrated solution requiring injection of less vehicle • unusually well-tolerated, even in large doses • fewer injections required • low viscosity makes administration easy

Complete information on administration and dosage is supplied in the package insert

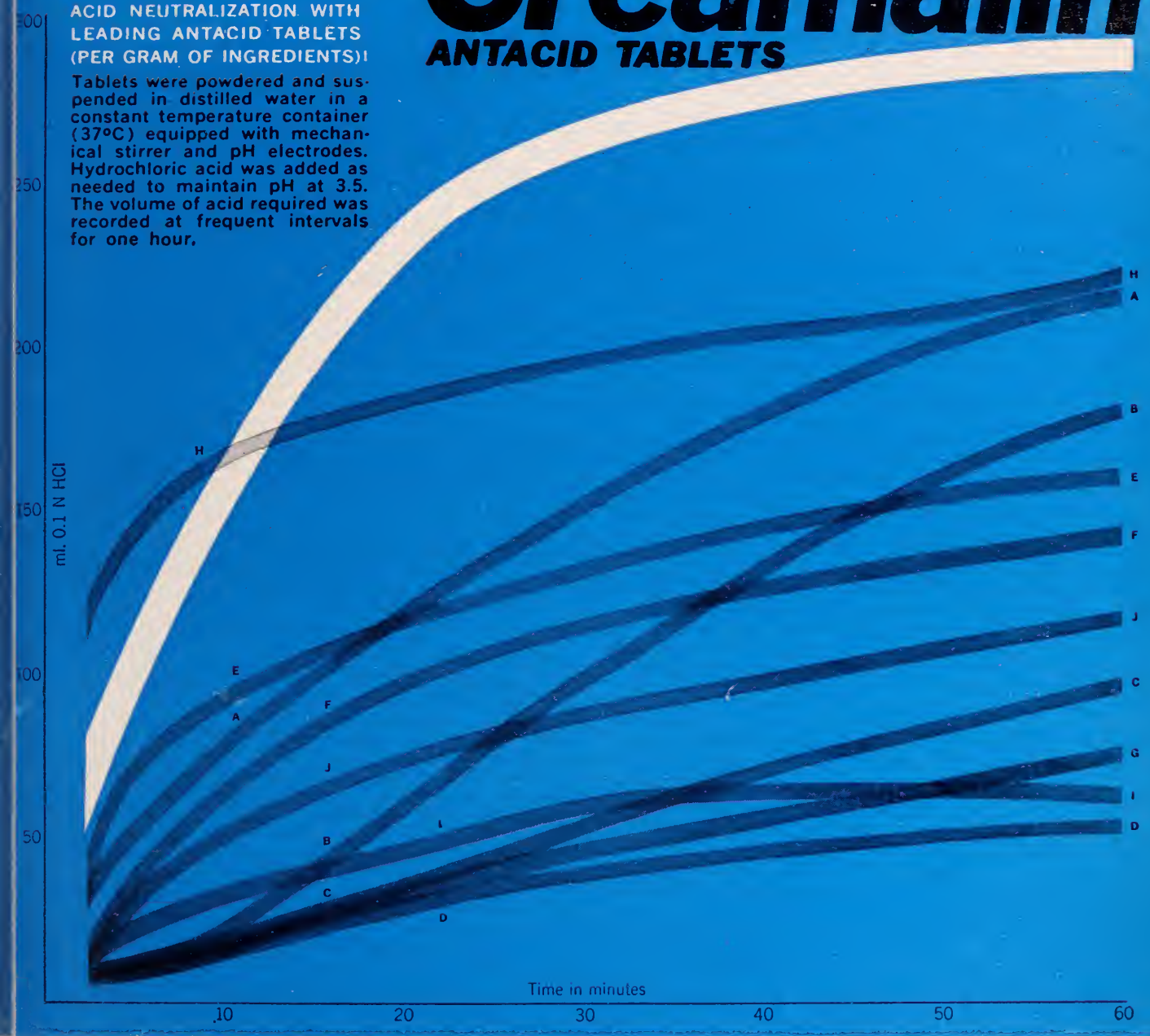
Supply: Vials of 2 and 10 cc., each containing 125 mg. of hydroxyprogesterone caproate in benzyl benzoate and sesame oil.

SQUIBB *Squibb Quality—The Priceless Ingredient*

"DELALUTIN" ® IS A SQUIBB TRADEMARK

More gastric acid neutralized faster...with new Creamalin®

ANTACID TABLETS



GREATLY HEIGHTENED REACTIVITY to acid characterizes the action of New Creamalin Antacid Tablets.[1,2] They act faster and longer than other leading tablets and neutralize considerably more acid.[1] These tablets provide virtually the same effects as a liquid[2] with the convenience of a tablet. New Creamalin tablets give faster, greater and more prolonged relief.

NOT CONSTIPATING, New Creamalin Antacid Tablets will not produce "acid rebound" or alkalosis. They have a pleasant taste.

Creamalin, trademark reg. U. S. Pat. Off.

EACH NEW CREAMALIN ANTACID TABLET contains 320 mg. of specially processed, highly reactive, short polymer dried aluminum hydroxide gel (stabilized with hexitol), with 75 mg. of magnesium hydroxide.

Adult dosage: Gastric hyperacidity—2 to 4 tablets as necessary. Peptic ulcer or gastritis—2 to 4 tablets every two to four hours. Tablets may be chewed, swallowed whole with water or milk, or allowed to dissolve in the mouth.

How Supplied: Bottles of 50, 100, 200 and 1000.

1. Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: *J. Am. Pharm. A. (Scient. Ed.)* 48:380, July, 1959. 2. Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: *J. Am. Pharm. A. (Scient. Ed.)* 48:384, July, 1959.

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FOR PEPTIC ULCER • GASTRITIS • GASTRIC HYPERACIDITY

no irritating crystals[1] · uniform concentration in each drop[2]

STERILE OPHTHALMIC SOLUTION

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PREDNISOLONE 21-PHOSPHATE-NEOMYCIN SULFATE

2,000 TIMES MORE SOLUBLE THAN PREDNISOLONE OR HYDROCORTISONE

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1. Lippmann, O.: Arch. Ophth. **57**:339, March 1957.
2. Gordon, D.M.: Am. J. Ophth. **46**:740, November 1958.

supplied: 0.5% Sterile Ophthalmic Solution NEO-HYDELTRASOL (with neomycin sulfate) and 0.5% Sterile Ophthalmic Solution HYDELTRASOL®. In 5 cc. and 2.5 cc. dropper vials. Also available as 0.25% Ophthalmic Ointment NEO-HYDELTRASOL (with neomycin sulfate) and 0.25% Ophthalmic Ointment HYDELTRASOL. In 3.5 Gm. tubes.

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MSD MERCK SHARP & DOHME Division of Merck & Co., Inc., Philadelphia 1, Pa.

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as a
"cold"...

to prevent
the sequelae
of u.r.i. ...
and relieve the
symptom complex

ACHROCIDIN®

Tetracycline-Antihistamine-Analgesic Compound Lederle

Sinusitis, otitis, tonsillitis, adenitis, bronchitis or pneumonitis develops as a serious bacterial complication in about one in eight cases of acute upper respiratory infection.(1) To protect and relieve the "cold" patient... ACHROCIDIN.

Usual dosage: 2 tablets or teaspoonfuls q.i.d. (equiv. 1 Gm. tetracycline). Each TABLET contains: ACHROMYCIN® Tetracycline HCl (125 mg.); phenacetin (120 mg.); caffeine (30 mg.); salicylamide (150 mg.); chlorothen citrate (25 mg.). Also as SYRUP, caffeine-free.

(1) Estimate based on epidemiologic study by Van Volkenburgh, V. A., and Frost, W. H.: Am. J. Hygiene 71:122, Jan. 1933.

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When blood pressure **must** come down

When you see symptoms of hypertension such as dizziness, headache, and fainting your patient is a candidate for Serpasil-Apresoline. Even when single-drug therapy fails, Serpasil-Apresoline frequently can bring blood pressure down to near-normal levels, reduce rapid heart rate, allay anxiety.

SUPPLIED: Tablets #2 (standard-strength, scored), each containing 0.2 mg. Serpasil and 50 mg. Apresoline hydrochloride; Tablets #1 (half-strength, scored), each containing 0.1 mg. Serpasil and 25 mg. Apresoline hydrochloride.

SERPASIL®-APRESOLINE®

hydrochloride (reserpine and hydralazine hydrochloride CIBA)

CIBA
SUMMIT, N. J.

In vitro facts and in vivo findings on new broad-spectrum

DECLOMYCIN

PROPERTIES · PERFORMANCE · IMPORTANCE

A MAJOR CONTRIBUTION TO ANTI-INFECTIVE THERAPY

PROPERTIES:

Greater inhibitory action ... lower daily intake than other tetracyclines

A unique new fermentation product of *Streptomyces aureofaciens,* DECLOMYCIN Demethylchlortetracycline achieves notably greater antibiotic activity against infections[2,4,7,8,10,14,19,20,24] because of two basic factors: (1) inherent potency, and (2) greater stability in most body fluids.[15,17,18,27] Actual clinical activity has, in many instances, been better than expected on the basis of *in vitro* sensitivity tests.[14,18,19]

Broad-spectrum control ... with far less antibiotic

Activity levels of DECLOMYCIN Demethylchlortetracycline are higher than those of previous broad-spectrum antibiotics. Hardier strains of various organisms appear to be somewhat more responsive.[4] Apparently some strains of Pseudomonas, Proteus and *A. aerogenes,* frequently refractory to therapy, are sensitive to DECLOMYCIN.[7,23,25,26]

DECLO

Sustained peak activity ... greater security of control

Prolonged retention and compatibility of DECLOMYCIN with body fluids provides peak activity between doses.[15,17,18,27] Inhibition of bacteria is more constant.

24-48 hours extra activity... protection against relapse

DECLOMYCIN maintains effective antimicrobial action for one to two days after stopping dosage.[7,14] Resurgence of a few viable pathogens, with relapse... and low patient defense against secondary bacterial invasion during the first post-therapy days . . . are largely offset.

MYCIN®

Demethylchlortetracycline Lederle

PERFORMANCE

Susceptibility Tests

Roberts, M. S., *et al.*[25]
New York, N. Y.

Pre-treatment sensitivity tests in 75 genitourinary patients showed DECLOMYCIN Demethylchlortetracycline to be superior against the large majority of organisms and in no instance inferior to tetracycline. DECLOMYCIN apparently has more effective coverage... several strains of *Proteus* and *A. aerogenes* responded.

Tolerance & Toxicity

Boger, W. P., and Gavin, J. J.[2]
Norristown, Pa.

Administration of the recommended 600 mg. (4 capsules) daily for 30 days to a small group of elderly patients revealed no hematologic, hepatic and urinary alteration or other abnormal finding. No clinical side effects were observed.

Gonococcal Infection

Marmell, M., and Prigot, A.[20]
New York, N. Y.

All except two of 63 patients with acute gonorrhea responded promptly to therapy with DECLOMYCIN. Fifteen received 250 mg. q.i.d. for one day, the remainder received 600 or 750 mg. in divided doses over one or two days. No side effects.

General Medicine

Lichter, E. A., and Sobel, S.[19]
Chicago, Ill.

One hundred and sixty-nine patients with various infections showed generally equivalent response to four dosage regimens, including the recommended level. Of 29 pneumococcal pneumonias, all recovered with 15 afebrile in 48 hours or less — except a few patients with preterminal underlying disease. All 42 scarlet fever patients recovered with 32 afebrile in 48 hours or less. Other patients also responded satisfactorily with few exceptions. No blood, liver or kidney toxicity found. G.I. side effects occurred in only 2 per cent at the recommended dosage, or less, and were easily reversible.

Respiratory Infection

Perry, D. M., *et al.*[22]
Seattle, Wash.

Good or fair response in 24 of 30 cases of acute bacterial pneumonia, and in all of six cases of acute bronchitis. Side effects occurred at higher dosage but were uniformly absent when dosage was limited to 600 mg. per day.

Various Infections

Finland, M., *et al.*[7]
Boston, Mass.

Eighty patients with various infections were treated with DECLOMYCIN Demethylchlortetracycline and an equal number with tetracycline. Therapeutic response was indistinguishable between the two groups. However, DECLOMYCIN Demethylchlortetracycline dosage was much lower (50 to 60 per cent of that of tetracycline.) In addition, incidence of side effects with demethylchlortetracycline was only half that experienced with tetracycline.

Pyelonephritis

Vineyard, J. P., *et al.*[29]
Dallas, Tex.

Therapy with DECLOMYCIN was successful in 12 of 13 patients with pyelonephritis. Sterile cultures were obtained in nine patients within six to 14 days. Among the organisms suppressed were strains of *A. aerogenes, E. coli* and paracolon bacillus. In most cases, DECLOMYCIN was used jointly with another antibiotic.

Soft Tissue Infection

Prigot, A., *et al.*[24]
New York, N. Y.

DECLOMYCIN was used alone or auxiliary to surgical measures in 150 cases of acute soft tissue infection, mostly ambulatory. Full resolution of infection was achieved in all cases, average length of treatment being six days. Dosage was 600 or 750 mg. daily. Side effects consisted of transitory G.I. disturbances in three cases.

DECLO

Urinary Infection

Trafton, H. M., and Lind, H. E.[28]
Brookline, Mass.

Clinical response was favorable in a majority of 50 cases of urinary tract infections with relief of symptoms, elimination, or marked reduction, of pyuria and with urine sterilization in some. DECLOMYCIN Demethylchlortetracycline was administered in one-half to one-third the daily milligram level of related antibiotics, for 8 days.

No significant diarrhea occurred in any case although mild nausea and upper G.I. symptoms were fairly common. Phototoxicity occurred in six cases.

Antibiotic-Resistant Infections

Compilation of reports of 210 clinical investigators.[23]

In 570 treated for a great variety of infections, DECLOMYCIN was successful in resolving infection or in effecting marked improvement in 81 per cent, after failure of other antibiotics.

Pediatric Infection

Fujii, R., *et al.*[9]
Tokyo, Japan

Therapeutic results, elicited in 309 pediatric patients with average daily dosage of 15 mg./kg., were equal to those produced by 30 mg./kg. of buffered tetracycline preparations. Satisfactory results were obtained in 75 per cent. No appreciable side effects when 15 mg./kg./day dosage was not exceeded.

Pediatric Infection

Hall, T. N.[12]
San Francisco, Cal.

All eight cases of ophthalmic, respiratory or otic infection responded to four to twelve days of DECLOMYCIN therapy (5 recovered, 2 greatly improved, 1 improved). One skin reaction, in a case receiving the higher trial dosage of 7 mg./lb. daily, occurred.

Pneumonias

Duke, C. J., *et al.*[5]
Washington, D. C.

Results were satisfactory in all 32 cases of acute bacterial penumonia, excepting for two caused by non-susceptible organisms. Over half had been complicated by pleural, suppurative, bronchial, or underlying structural lung problems. Dosage was low. No toxicity found. Acceptance and toleration were excellent.

Intestinal & Respiratory Infection

Hartman, S. A.[13]
Sherman Oaks, Cal.

Six cases of g.i. infection (diverticulitis, ileitis, colitis) responded in three to eight days on the lower milligram intake...even after failure in most with sulfa, neomycin or penicillin-streptomycin. Complete recovery was gained in 5 respiratory cases on a shorter schedule; another withdrew with occurrence of thrush. No other side effects were reported.

Respiratory Infection

Feingold, B. F.[6]
San Francisco, Cal.

All 13 upper or lower respiratory infections demonstrated very good response in 2-3 days on recommended dosage. No side effects were reported.

Various Infections

Compilation of reports of 210 clinical investigators.[23]

Of 1,904 patients with adequate follow-up treated for a wide diversity of infections, 87 per cent were reported as cured or improved. Most patients received one 150 mg. tablet every 6 hours. Therapy usually was for three to eight days. Side effects, mostly referable to the gastrointestinal tract, occurred in 200 patients.

PERFORMANCE

MYCIN®

Demethylchlortetracycline Lederle

PERFORMANCE *(continued)*

Respiratory Infection & Others

Gates, G. E.[11]
South Bend, Ind.

Of 65 cases, predominantly respiratory infections, but including some of cystitis and cellulitis, 50 had a good response, 12 were fair and three were failures. One of the failures was a case of chronic ulcerative colitis and two were respiratory infections. The only complication was a slight vulvular pruritus and burning tongue occurring near the end of a week's treatment of residual pneumonitis.

Pustular Dermatoses

Kanof, N. B., and Blau, S.[16]
New York, N. Y.

Eighty-five per cent of 67 patients responded with excellent or good results on a DECLOMYCIN schedule of one 150 mg. capsule q.i.d. for two to twelve weeks. Three poor responses were related to highly resistant organisms. No pruritus or drug eruptions developed. Only four cases showed nausea or diarrhea in the long therapeutic course.

Surgical Infection

Floyd, R. D., and Anlyan, W. G.[8]
Durham, N. C.

Successful results were generally obtained in 60 patients given 600 mg. DECLOMYCIN daily (or slightly less) for five to 15 days. No infection developed in the clean or contaminated prophylaxis group. Most frank infections responded...including several refractory to previous antibiotics. No toxicity evidenced. Intestinal toleration was excellent.

Wound Infections & Others

Meyer, B. S.[21]
Birmingham, Ala.

Thirty-five cases, chiefly prophylactic, and some traumatic-surgical wound infections were treated usually on one capsule DECLOMYCIN q. 6 h. for two to eight days. Over 80 per cent responded, including one with Pseudomonas etiology. Minor itching or nausea occurred in two; prominent nausea developed in one on a q. 4 h. schedule.

Topical & Wound Infections

Stewart, J.[26]
New Orleans, La.

Of 21 patients followed, 15 completely recovered, four improved in four to 42 days on 600 mg. daily. Seven had not responded to various other therapies. One had *A. aerogenes* predominance, complicated by Proteus and *E. coli*. Cases were traumatic-surgical-topical infections with some respiratory. One questionable reaction of anemia was encountered.

Oral Infection

Arbour, E. F.[1]
New Orleans, La.

Of four patients treated, three responded to one capsule DECLOMYCIN q. 6 h. for three days. No change in one case of chronic proliferating periodontitis. No adverse reactions seen.

Brucellosis

Chávez, Max, G.[3]
Mexico, D. F.

All nine patients infected with *Brucella melitensis* were afebrile on fourth or fifth day of DECLOMYCIN therapy and asymptomatic within 15 days. Treatment lasted for 45 days. No relapses occurred. Hepatic, renal, or hematologic toxicity was not seen. Minor or occasional intestinal reactions in some cases did not require discontinuance.

DECLO

IMPORTANCE...

in the average patient – DECLOMYCIN reduces the possibility of gastrointestinal intolerance and increases the likelihood of an uneventful therapeutic course. Variants of an infecting organism are less likely to survive the high, sustained activity and post-dosage control. Minor or major reverses or "setbacks" during therapy may be avoided. Susceptibility to secondary infection when dosage is terminated is counteracted by the "extra-day" activity.

in mixed infections—DECLOMYCIN provides satisfactory control of conditions involving multiple pathogens. Since organisms vary in sensitivity at given antibiotic levels, the higher DECLOMYCIN activity tends to inhibit a greater proportion of the less susceptible strains. Remission and bacteriologic cure can thus progress at a faster pace.

in the absorption-deficient – The high activity/intake ratio of DECLOMYCIN provides a wider margin of security for those with disturbed or abnormal absorption or with underlying gastrointestinal dysfunction. Inhibitory levels remain more than adequate in most.

under adverse host conditions—In debility, malnutrition, neoplasm, diabetes, or other organic, chronic or underlying disease, DECLOMYCIN may be vital to successful resolution of infection. *Generally in geriatrics,* for the same reason, DECLOMYCIN should often be a broad-spectrum of choice.

if an occasional dose is missed – The sustained action of DECLOMYCIN protects against possible loss of control. In the sleeping patient, an occasional dose may be foregone without adverse effect, while benefits of such rest are gained. Arbitrary rejection of a dose by pediatric or geriatric patients...simple forgetfulness...or postponing a dose will not appreciably reduce antibiotic activity provided these do not occur frequently.

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Demethylchlortetracycline Lederle

IMPORTANCE

DECLOMYCIN®

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CAPSULES, 150 mg., bottles of 16 and 100. *Dosage:* Average adult 1 capsule four times daily.

PEDIATRIC DROPS, 60 mg./cc. (custard flavor) in 10 cc. bottle with calibrated dropper. *Dosage:* 1-2 drops (3-6 mg.) per pound body weight per day—divided into 4 doses.

ORAL SUSPENSION, 75 mg./5 cc. teaspoonful (custard flavor) in 2 oz. bottle. *Dosage:* 3-6 mg./lb./day—divided in 4 doses.

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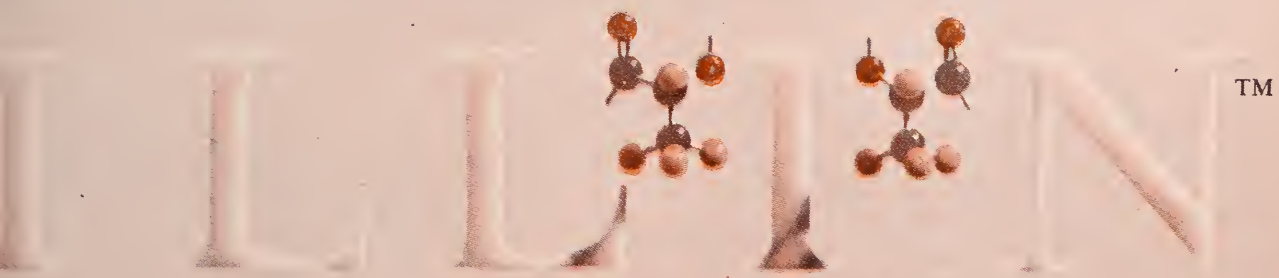

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Significance of complementary action of isomers in SYNCILLIN

The antibiotic effect of the clinically available mixture, SYNCILLIN, is greater than that of either of its two component isomers alone against many important pathogens, including some penicillin-resistant staphylococci. This phenomenon has been described as *Isomeric Complementarity*.

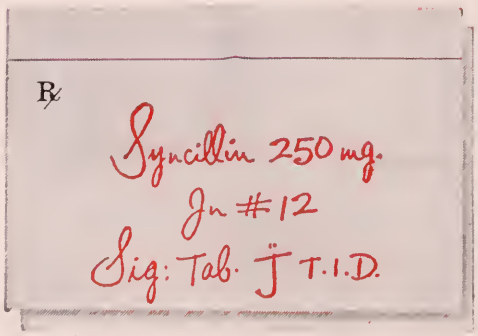
Significance of higher blood levels with SYNCILLIN

Higher blood levels may be of value with organisms of only moderate penicillin sensitivity where doubling the blood concentration may be essential for effective bactericidal action. In addition, these higher levels may be necessary where there is infection in areas with a poor blood supply. Under these circumstances a higher blood concentration may provide the increased diffusion pressure required to deliver adequate amounts to the tissue. Also, antibiotic activity of SYNCILLIN is directly proportional to oral dosage. Increasing the dosage may, therefore, enhance the drug's effectiveness in certain cases.

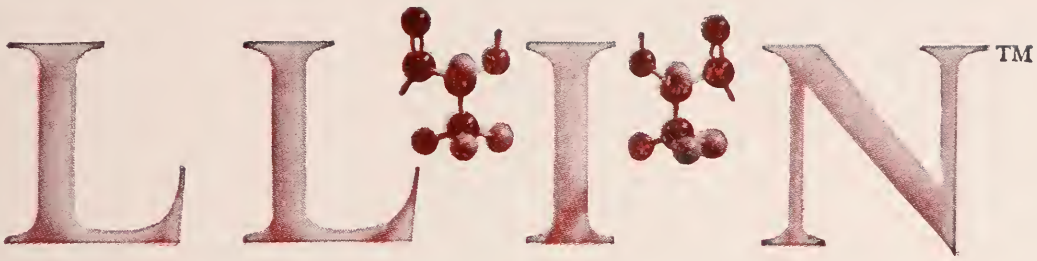
Efficacy of SYNCILLIN against staphylococci and other resistant organisms

Studies have shown that SYNCILLIN is effective *in vitro* against 60 to 75% of hospital "staph" strains, while penicillin G and penicillin V are now effective against only 30 to 50%.[1, 2] Therefore, if clinical judgment indicates the use of penicillin, SYNCILLIN would be expected to be the most effective. However, since some strains are still resistant to SYNCILLIN as well as to the other penicillins, cultures and sensitivity tests should be performed where indicated by clinical judgment.

There have recently been reports of decreased efficacy of penicillin in streptococcal[3] and gonococcal[4, 5] infections. The emergence of penicillin-resistant gonococci appears to be associated with an increase in the incidence of gonorrhea all over the world. When a less sensitive strain is encountered the higher blood levels produced by SYNCILLIN may be most helpful.



major therapeutic advantages accompany molecular asymmetry



Relation of intermittent blood levels SYNCILLIN antibacterial efficacy

SYNCILLIN, like all clinically available penicillins, is bactericidal. Periodic high blood concentrations may be sufficient to permit complete eradication of sensitive pathogens. According to Eagle,[6] "Soon after penicillin attains effective concentrations, the bacteria cease multiplying; and the bacteriostatic effect persists for a number of hours after penicillin has fallen to concentrations that are wholly ineffective. . . . The therapeutic significance of this postpenicillin recovery period is enhanced by the fact that the recovering bacteria, damaged but not killed by the previous exposure to penicillin, are abnormally susceptible to the host defenses. In consequence, the bactericidal process *in vivo* continues for many hours after the drug itself has fallen to ineffective concentrations."

Reduced rate of inactivation SYNCILLIN by staph penicillinase

Bacterial resistance to penicillin has been attributed to the action of penicillin-inactivating enzymes produced by the invading organisms. SYNCILLIN is less affected by staphylococcal penicillinase than either of its component isomers. Further, SYNCILLIN is shown to be less inactivated by this enzyme than penicillin V or penicillin G. Penicillinase from *B. cereus* likewise inactivates SYNCILLIN less rapidly than penicillin V or G.

Indications: SYNCILLIN is recommended in the treatment of infections caused by pneumococci, streptococci, gonococci, corynebacteria, and penicillin-sensitive staphylococci. In addition, SYNCILLIN is effective against certain strains of staphylococci resistant to other penicillins. SYNCILLIN, like other oral penicillins, is not recommended at the present time in deep-seated or chronic infections, subacute bacterial endocarditis, meningitis, or syphilis.

Dosage: 125 mg. or 250 mg. three times daily, depending on the severity of infection. Larger doses (e.g., 500 mg. t.i.d.) may be used for more severe infections. SYNCILLIN may be administered without regard to meals. Beta hemolytic streptococcal infections should be treated with SYNCILLIN for at least ten days.

Precautions: At the present time it is not possible to draw definite conclusions regarding the incidence of allergenicity to SYNCILLIN or its cross-allergenicity with natural penicillins. *Therefore, the usual precautions for oral penicillin therapy should always be observed.* Patients with histories of asthma, hay fever, urticaria, or previous reactions to penicillin should be watched with special care. Administration of oral penicillin, in rare instances, may provoke acute anaphylaxis, particularly in penicillin-sensitive individuals.
Diarrhea has been reported occasionally following heavy dosage. If this occurs, lengthen the interval between dosages.
If superinfection occurs during therapy, appropriate measures should be taken. Since some strains of staphylococci are resistant to SYNCILLIN as well as to other penicillins, cultures and sensitivity tests should be performed where indicated by clinical judgment. As is true with all antibiotics, clinical response does not always correlate with laboratory bacterial sensitivity reports.

Supply: 125 and 250 mg. tablets, bottles of 25 and 100. 125 mg. powder for oral solution, 60 ml. vials.

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a true "tranquilaxant"
keeps the patient
on the job

THE FIRST TRUE "TRANQUILAXANT"

Trancopal®

relieves painful muscle spasm and relaxes the patient

Impressive numbers of patients with low back pain and other musculospastic conditions treated with Trancopal have been freed of symptoms and enabled to return to their usual activities, according to newly published clinical reports. In a recent study by Lichtman,[1] Trancopal broug excellent to satisfactory muscle relaxation tc 817 of 879 patients. The patients in this group suffered from skeletal muscle spasm associated with low back pain (361 cases), stiff neck (128 cases), bursitis (177 cases), and other skeletal muscle disorders (213 cases). Side effects were rare (2 per cent of patients), and it was not necessary to discontinue medication in any of the patients. Lichtman comments: "Chlormethazanone [Trancopal] not only relieved painful muscle spasm, but allowed the patients to resume their normal activities with no interference in performan of either manual or intellectual tasks."[2]

When you prescribe Trancopal for musculoskeletal disorders, you can confidently expect that your patients will be relieved of the pain and stiffness. You can be sur of their speedy return to everyday work and recreation.

Iullin and Epifano call Trancopal "...a very effective skeletal muscle spasmolytic."[3]
'hey found that Trancopal brought good to excellent relief to all of 39 patients with
keletal muscle spasm related to trauma, bursitis, rheumatoid arthritis, osteoarthritis, and
ntervertebral disc syndrome. (No side effects were noted except that one patient had slight
ryness of the mouth.)
'he pattern is similar in every new series reported: Ganz,[4] DeNyse,[5] Shanaphy[6] and Stough.[7]

Trancopal is a true "tranquilaxant"

'rancopal "...combines the properties of tranquilization and skeletal muscle relaxation
vith no concomitant change in normal consciousness."[6]

Relieves dysmenorrhea

Trancopal not only is valuable in treating patients with low back pain and other musculoskeletal disorders, but is also very effective in bringing relief from menstrual cramps and discomfort. Shanaphy suggests that Trancopal may help the patient by its combination of muscle relaxant and tranquilizing actions, and he finds that "...the continued use of chlormezanone [Trancopal] as a therapeutic agent in dysmenorrhea is advisable."[6] Trancopal was effective in 82 per cent of his series of 50 patients. In another study, which dealt with 52 adolescent girls and 23 women, Stough[7] reported that Trancopal gave complete or moderate relief in 86.4 per cent.

Alleviates tension

And, of course, Trancopal is also very useful in the treatment of patients in anxiety
and tension states. As Ganz says, "...a most valuable drug for relieving tension,
apprehension and various psychogenic states...allows the patient to use his energies in
a more productive manner in overcoming his basic problems."[4]

Trancopal

a true "tranquilaxant"

that relieves skeletal muscle spasm and relaxes psychogenic tension without troublesome side effects, and keeps the patient on the job.

Indicated for...

Musculoskeletal disorders		Psychogenic disorders
Low back pain (lumbago)	Fibrositis	Anxiety and tension states
Neck pain (torticollis)	Ankle sprain, tennis elbow	Dysmenorrhea
Bursitis	Myositis	Premenstrual tension
Rheumatoid arthritis	Postoperative muscle spasm	Asthma
Osteoarthritis		Angina pectoris
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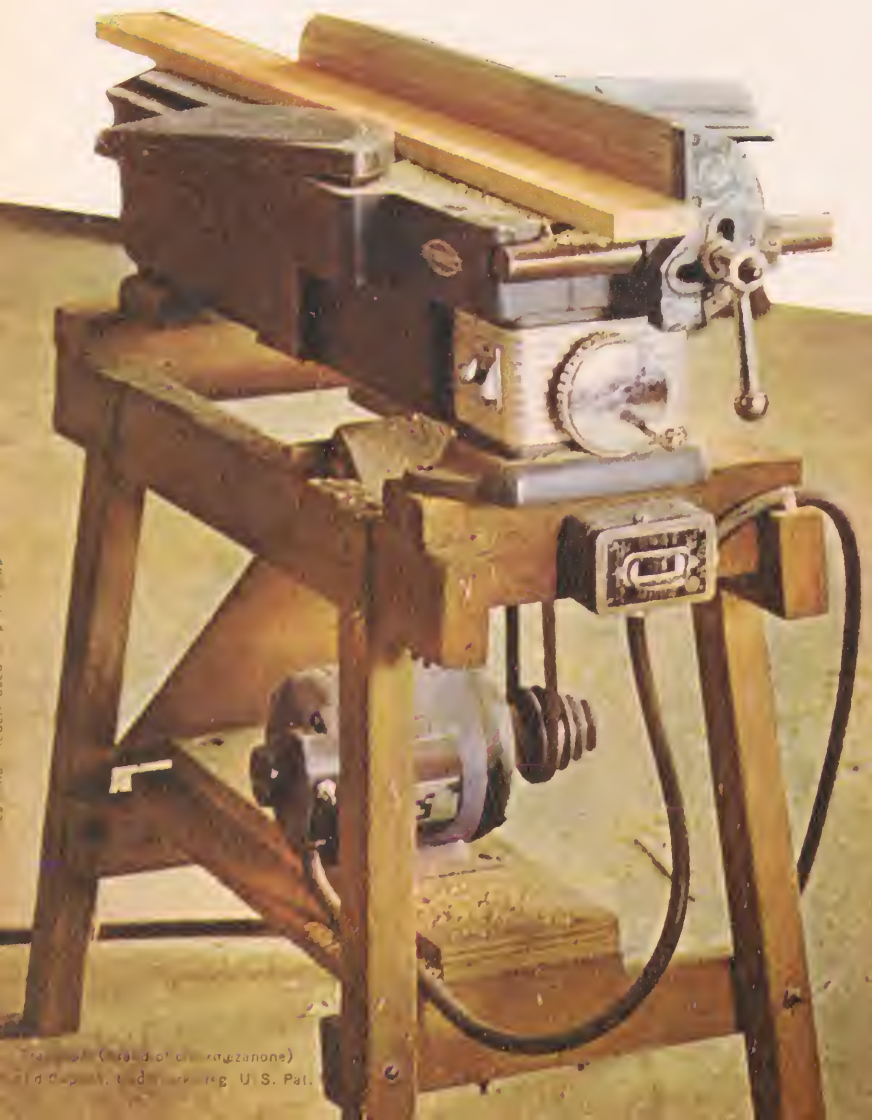

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(Continued from page 1138)

Society and was a life member of the Florida Medical Association, having held membership for 53 years. He was also a member of the American Medical Association.

In 1903, Dr. Barnes and Miss Lena Johnson of Chattahoochee were united in marriage. Mrs. Barnes preceded her husband in death in 1953. Three children survive, Benjamin F. Barnes III and Miss Marjorie Barnes of Chattahoochee and Mrs. Olivia Fines of Tuscaloosa, Ala. Other survivors include four grandchildren.

William Wellington George

Dr. William Wellington George of West Palm Beach died suddenly following a massive cerebral hemorrhage on Sept. 30, 1959. He was 61 years of age.

Born in Washington, D. C., on July 10, 1898, Dr. George received his medical education at Georgetown University, where he was awarded the degree of Doctor of Medicine in 1922. He then served internships in White Plains, N. Y., and Macon, Ga. His medical fraternity was Phi Chi. He engaged in postgraduate work at Tulane University School of Medicine in 1936 and 1937 and later at several other medical postgraduate centers.

Dr. George came to West Palm Beach from Washington in 1924 and had continued to engage in the practice of internal medicine there since that time. He was a member of the active staff of the Good Samaritan and St. Mary's Hospitals and had served on the Medical Executive Committee of St. Mary's Hospital since its inception. He held membership in St. Ann's Catholic Church. A veteran of World War I, he was affiliated with American Legion Post 12 of West Palm Beach.

A member of the Palm Beach County Medical Society, Dr. George served that body as president in 1934. In May 1959 he was presented with a life membership in the Florida Medical Association, having been a member for 35 years. He was also a member of the American Medical Association, Southern Medical Association and American Therapeutic Society.

Dr. George is survived by his widow, the former Miss Isabel Bryan of Maryland, to whom he was married in July 1922, and a sister, Mrs. Douglas Long, of Seattle, Wash.

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Arthur Ray Beyer

Dr. Arthur Ray Beyer of Tampa died in that city on Sept. 27, 1959. He was 79 years of age.

The son of Mr. and Mrs. Thomas Beyer, Dr. Beyer was born in Syracuse, N. Y., on June 23, 1880. He came to Florida as a child and spent most of his youth in Winter Park. After receiving his academic degree from Rollins College, he attended the Louisville Medical College in Louisville, Ky., where he was awarded the degree of Doctor of Medicine in 1907.

Upon graduation, he located immediately in Tampa and continued to practice there for more than half a century. In 1913 he opened offices in the Citizens Building before the building was fully completed and remained there until he retired in July 1958. His specialty was surgery. He served on the staff of the Tampa General Hospital, St. Joseph's Hospital, Clara Frye Hospital and Centro Asturiano Hospital. He was a Mason and a member of Egypt Temple Shrine. He held membership in the First Presbyterian Church.

Dr. Beyer was a member of the Hillsborough County Medical Association and was a life member of the Florida Medical Association, having been a member for 51 years. He also was affiliated with the American Medical Association, the Association of Seaboard Air Line Railroad Surgeons, the American Association of Railway Surgeons, the Southeastern Surgical Congress, the Medical Aviation Association and the International College of Surgeons.

Surviving are the widow, Mrs. Eleanor M. Beyer; a daughter, Mrs. Margaret Alberta Kirkland, and a sister, Mrs. Emily E. Bonfield, all of Tampa.

Hugh Howard Barfield

Dr. Hugh Howard Barfield of Ocala died on Sept. 27, 1959, following a sudden heart attack at his home. He was 56 years of age.

The son of the late John Henry and Romanie Overton Barfield, Dr. Barfield was born on Sept. 3, 1903, at Ashland, Ala. He received his academic schooling at Howard University in Birmingham and at the University of Alabama. For his medical training he attended Emory Uni-

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...safely lowers blood sugar in mild, moderate
and severe diabetes, in children and adults

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low

versity School of Medicine in Atlanta, where he was graduated in 1932. He was a member of Pi Kappa Phi and Pi Beta Phi medical fraternity.

After spending three years as an intern and resident at Grady Hospital in Atlanta, Dr. Barfield engaged in the private practice of medicine in that city from 1935 to 1940. Entering the Army Medical Corps as a reserve officer in 1940, he served for five years during World War II and at the time of his discharge was Chief of Surgery at Fort Barrancus Station Hospital.

Upon release from military service in 1945, Dr. Barfield re-entered the private practice of medicine. He located in Ocala and practiced there for 14 years. Locally, he was a member of the First Baptist Church. He was a thirty-second degree Mason, a member of Morocco Temple in Jacksonville and a member of the Ocala Shrine Club, the Ocala Elks Club, and the Loyal Order of Moose.

Dr. Barfield was a member of the Marion County Medical Society. He also held membership in the Florida Medical Association and the American Medical Association.

He is survived by his widow, the former Miss Sally Farrell, to whom he was married in 1942 at Fort Jackson, S. C. Also surviving are one sister, Mrs. W. A. Hodges, of Atlanta; and two brothers, Dr. John O. Barfield, of St. Petersburg, and Vernon H. Barfield, of Jackson, Miss.

Frank Ernest Irons

Dr. Frank Ernest Irons of Winter Haven died in that city on Oct. 6, 1959, following an illness of several months. He was 81 years of age.

Born in Pickaway, W. Va., in 1877, Dr. Irons was the son of Dr. Benjamin Irons and Amanda Johnson Irons. He was graduated from Hampton-Sydney College in 1899 and was awarded the degree of Doctor of Medicine by the Medical College of Virginia in 1905.

Locating first in North Florida, Dr. Irons moved to Winter Haven in 1910. He practiced there for nearly half a century, retiring in 1958 because of ill health. Locally, he was an honorary member of the staff of the Winter Haven Hospital and a member of the First Presbyterian Church.

(Continued on page 1174)

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Methyl Testosterone	2.5 mg.
Ethinyl Estradiol	0.02 mg.
Thiamine Hydrochloride	6 mg.
Riboflavin	3 mg.
Pyridoxine Hydrochloride	6 mg.
Vitamin B-12	2 mcg.
Folic Acid	0.33 mg.
Panthenol	5 mg.
Choline Bitartrate	20 mg.
Inositol	15 mg.
1-Lysine Monohydrochloride	100 mg.
Vitamin E (a-Tocopherol Acetate)	3 mg.
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Trace Minerals as: Iodine 0.05 mg., Magnesium 2 mg., Manganese 1 mg., Cobalt 0.1 mg., Zinc 1 mg.

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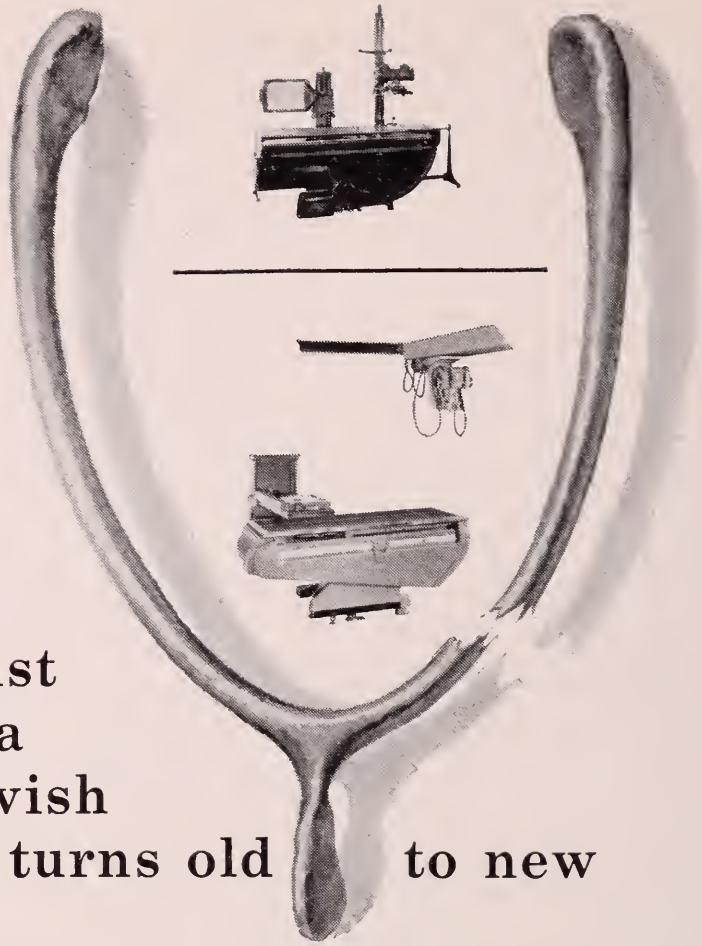

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in the Therapy of

ACUTE PHARYNGITIS, ESPECIALLY WITH LYMPHADENITIS

Ideally, selection of the proper antibiotic for treatment of acute pharyngitis should await the laboratory reports on the susceptibility of the infecting bacteria. But the busy practitioner who sees many patients a day during the upper respiratory infection season may sometimes find it difficult to avoid the empirical choice of an antibiotic. Unfortunately, this practice may sometimes result in therapeutic failure.

No matter what the pressure of the immediate situation, it is worthwhile to consider taking a bacterial specimen from the infected pharynx for culture and sensitivity studies before starting treatment. Thus, a rational basis will be provided for changing the antibiotic should the first choice prove ineffective.

Which Antibiotic?

All other things being equal, the drug of choice is the one to which the pathogen is most susceptible. But if the exigencies of the situation force the physician to a prompt use of antibiotic, a broad-spectrum preparation that produces immediate high blood levels (e.g., tetracycline phosphate complex, TETREX) probably has the best chance of controlling the pathogen.

Later, the laboratory report frequently may indicate that any one of several antibiotic agents would be equally effective against the particular microorganism in question. In such a case other factors such as frequency and severity of side effects, sensitizing potential and toxicity should be considered.

If the acute pharyngitis in question should be due to gram-negative Klebsiella[1], penicillin will be of no value, nor will erythromycin be effective. However, this organism is susceptible to tetracycline. If the pathogen should turn out to be gram-positive Streptococcus or Staphylococcus, then penicillin, erythromycin, and tetracycline may all be effective against it.

Penicillin, however, in addition to having a limited spectrum, also causes many minor and some serious sensitivity reactions. In a recent survey[2] it was found that penicillin produced severe skin reactions. But most important was the observation that anaphylactic shock, with a fatality rate of about 9 per cent, was the most frequent serious reaction. Such severe reactions are almost always associated with parenteral administration.

The tetracyclines (e.g., TETREX) have the advantages of a broad range of antimicrobial activity and low toxicity. And in addition, the physician does not have to trouble himself or his patients with repeated blood studies when he prescribes TETREX. Minor reactions such as gastric upsets or mild skin rashes occur occasionally. The most serious side effects are staphylococcal and monilial overgrowth, but these are rare and can be adequately controlled.

Some Microorganisms Susceptible[a] *to Tetracycline* (TETREX)[b]

Streptococcus; Staphylococcus; Pneumococcus; Gonococcus; Meningococcus; *C. diphtheriae; B. anthracis; E. coli;* Proteus; *A. aerogenes; K. pneumoniae;* Shigella; Brucella; *P. tularensis; H. influenzae; T. pallidum;* Rickettsiae; Viruses of psittacosis and ornithosis, lymphogranuloma inguinale, primary atypical pneumonia; *E. histolytica; D. granulomatosis.*

[a] Some strains are not susceptible.

[b] Table adapted from Goodman, L. S., and Gilman, A.: The Pharmaceutical Basis of Therapeutics, 2nd edition, New York, The Macmillan Co., 1956, pp. 1322-1323.

High blood, body fluid, and tissue levels of active drug are quickly attained when the new phosphate preparation of tetracycline (TETREX) is used.

The semisynthetic tetracyclines have been in constant use since they were introduced in 1952. They have been proved clinically and have established themselves as safe, effective, and valuable antibiotic agents. But the final decision, the choice of agent, and the control of therapy must remain where it has always been, in the hands of the individual physician.

References: 1. Zinsser, H.: A Textbook of Bacteriology, 11th edition, New York, Appleton-Century-Crofts, 1957, p. 409. 2. Welch, H.; Lewis, C. H.; Weinstein, H. L., and Boeckman, B. B.: Severe reactions to antibiotics. A nationwide survey. Antibiotic Med. & Clin. Ther. 4:800 (December) 1957.

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a potent thymoleptic . . .
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Does act effectively in *all* types of depression regardless of severity or chronicity.

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References: 1. Ayd, F. J., Jr.: Bull. School Med., Univ. Maryland *44*:29, 1959. 2. Azima, H., and Vispo, R. H.: A.M.A. Arch. Neurol. & Psychiat. *81*:658, 1959. 3. Lehmann, H. E.; Cahn, C. H., and de Verteuil, R. L.: Canad. Psychiat. A. J. *3*:155, 1958. 4. Mann, A. M. and MacPherson, A. S.: Canad. Psychiat. A. J. *4*:38, 1959. 5. Sloane, R. B.; Habib, A., and Batt, U. E.: Canad. M.A.J. *80*:540, 1959. 6. Straker, M.: Canad. M.A.J. *80*:546, 1959. 7. Strauss, H.: New York J. Med. *59*:2906, 1959.

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When you want to prescribe a regimen to reduce serum cholesterol and beta lipoproteins, are drastic diet changes necessary?

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Obviously, in any special diet, the fewer required changes in the patient's eating habits, the more likelihood there is that the patient will adhere to the prescribed diet.

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Never hydrogenoted—completely solt free

Eoch pint of Wesson contains 437-524 Int. Units of Vitomin E.

(Continued from page 1165)

Dr. Irons was a member and past president of the Polk County Medical Association. He became a member of the Florida Medical Association in 1916 and through the years also held membership in the American Medical Association.

Surviving are the widow, Mrs. Betty Washington Irons of Winter Haven; two daughters, Mrs. Harold Beebe of Riverside, Conn., and Mrs. Nancy Fitzgerald of Winter Haven; one sister, Miss May Irons of Fort Meade; and two grandchildren.

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Eaton George Lindner

Dr. Eaton George Lindner of Ocala died at the Munroe Memorial Hospital in that city on Oct. 20, 1959, following an illness of several months. He was 79 years of age.

Representing the third of four generations of Lindners in the medical profession, Dr. Lindner was born Dec. 20, 1879, at Clay Center, Kan. He was the son of Dr. Carl Lindner, a practicing physician in Kansas, and the grandson of Dr. Ernst Lindner, a native of Germany who came to Florida in 1839 representing a group of prospective settlers from Ohio. From the time he was six years old until he was 12, he spent the winters with his parents at their orange grove in Anthony, near Ocala. They then moved from Kansas to their grove at Anthony, and he attended school there. Later, he attended the Lake City Military Academy and the Florida Agriculture College, where he received the Bachelor of Science degree. In 1904 he was awarded the degree of Doctor of Medicine by the Miami Medical College at Cincinnati.

After graduation, Dr. Lindner returned to Anthony, practicing there for two years before locating in Ocala in 1906. He continued to engage in the general practice of medicine there through the years, serving as city physician for 17 years, county physician for 32 years, and surgeon for the Atlantic Coast Line Railroad for 20 years and the Seaboard Air Line Railway for 40 years. He was on the staff of the Marion General Hospital from 1910 to 1927, and joined

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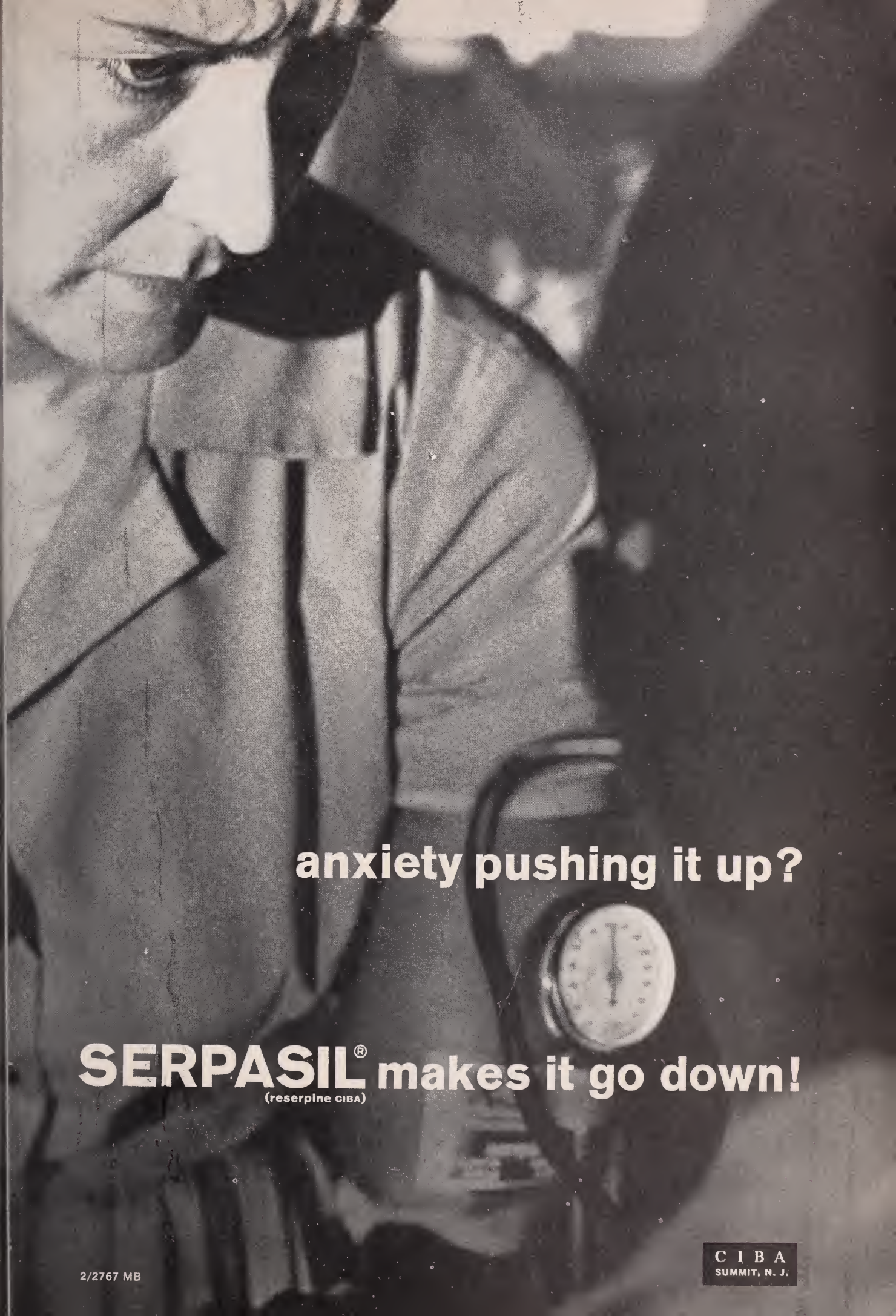
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the staff of the new Munroe Memorial Hospital in 1928, serving until his retirement from practice 28 years later. In 1956 he retired from the Florida State Board of Health after serving for 16 years. Because of ill health, he discontinued his practice altogether that same year and left his son, Dr. John D. Lindner, also of Ocala, to carry on the family tradition as the fourth generation physician and the third Dr. Lindner to practice medicine in Marion County. Locally, Dr. Lindner was Ocala's oldest Elk, having joined Lodge 286 in 1904. He was also a charter member of the Lion's Club and was active in the social and civic life of the community for more than half a century.

Dr. Lindner was a member of the Marion County Medical Society and was a life member of the Florida Medical Association, having held membership for 54 years. He also held membership in the American Medical Association.

In addition to the son, Dr. Lindner is survived by the widow, the former Justine Rhody, to whom he was married on Dec. 20, 1917, in Jacksonville; a daughter, Mrs. C. B. Wood, of McLan, Va.; and three grandsons and two granddaughters. Also surviving are a son and a daughter by a former marriage, George D. Lindner, of Jackson, Mich., and Mrs. C. H. Corey, of Alexandria, Va.; and five grandchildren.

Cleveland C. Fuqua

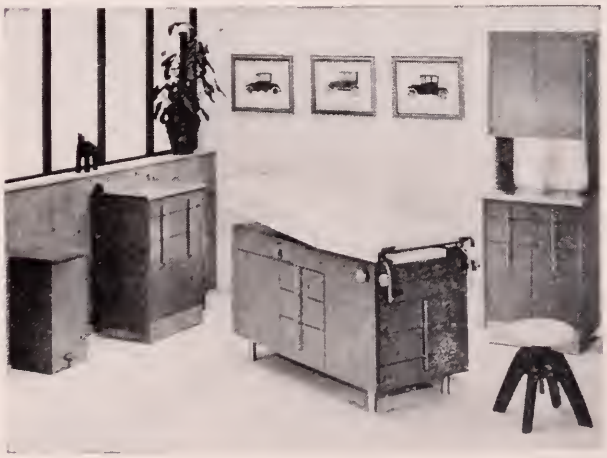
Dr. Cleveland C. Fuqua of Hilliard died on Nov. 8, 1959, in a Jacksonville hospital. He was 71 years of age.

Dr. Fuqua was born on Nov. 3, 1888, in Clayton, Ala. He received his medical education at the Southern Medical College in Atlanta and the Medical College of Georgia in Augusta. Upon graduation, he entered the general practice of medicine in Hilliard in 1912. After practicing 34 years in Hilliard and the surrounding area, he retired in 1946. He was also a registered pharmacist and a member of the Florida Pharmaceutical Association. Locally, he was a member of the Baptist Church.

An honorary member of the Nassau County Medical Society, Dr. Fuqua also held honorary membership in the Florida Medical Association. In addition, he was a member of the American Medical Association.

Surviving are the widow, Mrs. Bertie H. Fuqua, of Hilliard; a son, Cleveland C. Fuqua

The distinctive PREMIERE suite



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Jr., of Jacksonville; and four grandchildren, Wayne, Lane and Debra, all of Jacksonville, and Charles Robert, of Altus, Okla. Other survivors include a foster mother, Mrs. J. D. Fuqua, of Clayton, Ala.; four sisters, Mrs. Lelia McClure, of Troy, Ala., Mrs. Maude Beatty, of Birmingham, Ala., Mrs. Anna Bell Lee, of Auburn, Ala., and Mrs. Mary McGilvray, of Clayton, Ala.; and two brothers, John D. Fuqua, of Altha, Fla., and Henry C. Fuqua, of Clayton, Ala.

Frederic Hugh Wood

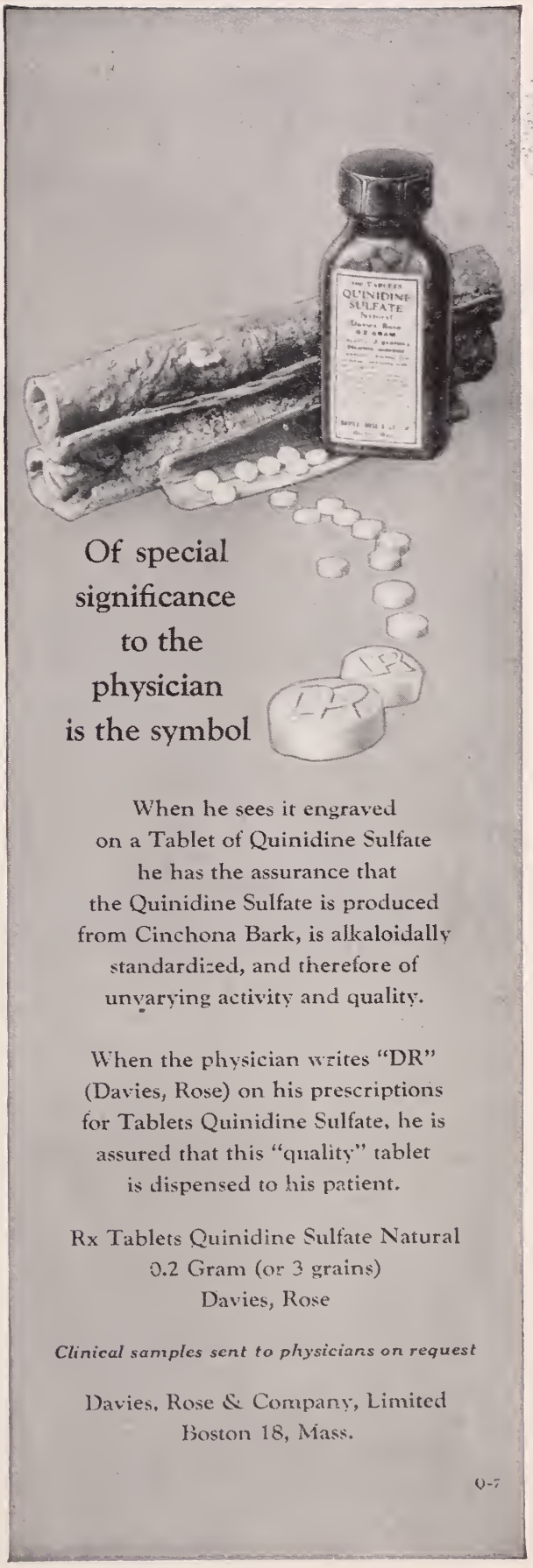
Dr. Frederic Hugh Wood of Bradenton died on Nov. 5, 1959, at the University of Florida Hospital in Gainesville. He was 42 years of age.

Dr. Wood was born in Philadelphia in 1917. He was a graduate of Rensselaer Polytechnic Institute, Troy, N. Y., and received his medical degree from Albany Medical College, Albany, N. Y., in 1944. He interned at the Medical Center, Jersey City, N. J., and served in the Medical Corps in World War II. Subsequently, he was a resident in urology at the University Hospital in Columbus, Ohio, and an instructor in urology at Ohio State University College of Medicine. While in practice in Hammond, Ind., he was a Clinical Assistant in Urology at the University of Illinois College of Medicine in Chicago. He was certified by the American Board of Urology in 1953. His medical fraternity was Nu Sigma Nu.

Coming to Florida in 1954, Dr. Wood located in Bradenton and restricted his practice to urology. He was an active member of the staff of Manatee Veterans Memorial Hospital in Bradenton as well as a member of the consulting staff of Memorial Hospital in Sarasota. He served as both secretary and treasurer of the medical staff of the Manatee Hospital. Locally, he was a member of the Presbyterian Church.

Dr. Wood was a member of the Manatee County Medical Society, the Florida Medical Association and the American Medical Association. He also held membership in the Chicago Urological Society, Indiana State Medical Society, Southeastern Section of the American Urological Association and Florida Urological Society.

Surviving are the widow, Mrs. Edith J. Wood, four daughters, Shirley, Patricia, Mary and Linda, and two sons, James and Richard, all of Bradenton.



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Wein, A. B.: The Use of Carisoprodol in Orthopedic Surgery and Rehabilitation. Proceedings of the Symposium on The Pharmacology and Clinical Usefulness of Carisoprodol. Wayne State University Press, Detroit, 1959, p. 156.

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Cooper, C. D., and Epstein, J. H.: The Clinical Evaluation of Carisoprodol by a double-blind technique. Ibid. p. 97.

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ANESTHESIOLOGIST: Board eligible, age 31, married, seeks group or solo opportunity, preferably in south Florida. Florida license. Write 69-364, P. O. Box 2411, Jacksonville, Fla.

WANTED: Radiologist seeking associate—congenial Orlando area. Limited volume, currently diagnosis only. Some hospital work. Florida license required. Write 69-322, P.O. Box 2411, Jacksonville, Fla.

WANTED: Two young associates for General Practice. One with training in anesthesia, the other in surgery, to be associated with General Practicioner with 28 bed hospital. Florida license required. Will guarantee suitable associates $1000 per month with partnership later. Write 69-352, P. O. Box 2411, Jacksonville, Fla.

WANTED: Young General Practitioner for associateship with established physician in greater Jacksonville area. General and industrial practice. Write 69-350, P. O. Box 2411, Jacksonville, Fla.

PHYSICIANS WANTED: New building in unopposed location in fast developing section of Fort Lauderdale area. Reasonable rent. Special consideration given men who are starting out. Write 69-369, P. O. Box 2411, Jacksonville, Fla.

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FOR SALE: To medical doctor. Three bedroom, two bath, red brick residence and frame clinic building in small town north central Florida. 30 miles from Gainesville. One other doctor between this town and Gulf Coast. Write 69-368, P. O. 2411, Jacksonville, Fla.

WANTED: General Practitioner for city of 1800, well populated agricultural area. Only physician in area retiring. Excellent hospital eleven miles. Write Box 538, Belleview, Fla.

SITUATION WANTED: General Surgeon, Board certified, age 55, Florida license, would like association with another surgeon or group. Write 69-371, P.O. Box 2411, Jacksonville, Fla.

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conditions for a fast comeback... as in acute hemorrhoids...

SUNDAY, 9 A.M.: VARIDASE for painful thrombotic hemorrhoid. 2:30 P.M.: pain greatly reduced, less swelling and inflammation.

MONDAY: size down to small tab; acute inflammation disappeared.*

Varidase activates natural fibrinolytic factors, to limit undesirable inflammatory response and speed healing.

Dramatic reduction of pain is often the first sign of improvement; swelling and redness rapidly diminish. Drugs and natural regenerative factors readily penetrate the inflammatory barrier to effect total remission faster . . . in trauma or infection.

Varidase Buccal Tablets contain:
10,000 Units Streptokinase. 2,500 Units Streptodornase.
Supplied: Boxes of 24 and 100 tablets

*Peterman, R. A.: Clinical report cited with permission.

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Whenever the diet is faulty, the appetite poor, or the loss of food is excessive

through vomiting or diarrhea—

Valentine's
MEAT EXTRACT

stimulates the appetite,

increases the flow of digestive juices,

provides: supplementary amounts of vitamins, minerals and soluble proteins,

extra-dietary vitamin B_{12},

protective quantities of potassium, in a palatable and readily assimilated form.

Supplied in bottles of 2 or 6 fluidounces.

DOSAGE *is 1 teaspoonful two or three times daily; two or three times this amount for potassium therapy.*

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Block, Jerome G., Miami Beach
Boggus, Argin A. Jr., Tavares
Britton, John B., Fernandina Beach
Brown, Harvey E. Jr., Coral Gables
Cobb, Sanford, Miami
Colsky, Jacob, Miami
Danielson, Harry E. Jr., Coral Gables
Darrow, Robert S., New Port Richey
DeFelice, Eugene A., No. Miami Beach
DeLaughter, George D. Jr., Daytona Beach
Doody, Thomas M., Miami
Eckert, William G., Tampa
Edwards, Albert T. (Col.), Miami
Fierer, Eugene M., Miami Beach
Fine, Seymour H., No. Miami
Finney, Roy P. Jr., Tampa
Guensch, Walter A., Clearwater
Handte, Robert E., Miami
Hogan, James E. (Col.), Miami
Hudson, Howard S., St. Petersburg
Lester, Charles F., Miami
Lubow, Henry, Coral Gables
Marquez, Antonio H., Miami
Mezer, Joseph H., Miami Beach
Moore, William A. III, Tampa
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Reavis, William F., Eustis
Register, Harold E., Miami
Rizika, Harold P., Miami
Rockwell, Elizabeth K., Tampa
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to ensure rapid control of infection throughout the urogenital system

Rapid bactericidal action against a wide range of gram-positive and gram-negative bacteria including organisms such as staphylococci, Proteus and certain strains of Pseudomonas, resistant to other agents ▪ actively excreted by the tubule cells in addition to glomerular filtration ▪ negligible development of bacterial resistance after 8 years of extensive clinical use ▪ excellent tolerance—nontoxic to kidneys, liver and blood-forming organs ▪ safe for long-term administration

AVERAGE FURADANTIN ADULT DOSAGE: 100 mg. q.i.d. with meals and with food or milk on retiring. Supplied: Tablets, 50 and 100 mg.; Oral Suspension, 25 mg. per 5 cc. tsp.

REFERENCES: 1. Campbell, M. F.: Principles of Urology, Philadelphia, W. B. Saunders Co., 1957. 2. Colby, F. H.: Essential Urology, Baltimore, The Williams & Wilkins Co., 1953.

NITROFURANS—a unique class of antimicrobials—neither antibiotics nor sulfonamides

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in pneumonia

. . . into a mixed culture of the three organisms commonly involved in pneumonia . . . *K. pneumoniae*, *Diplococcus pneumoniae*, and *Staphylococcus aureus* (in this case a resistant strain) . . . we introduce the five most frequently used antibiotics.

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Now available: new Panalba Half-Strength Capsules in bottles of 16 and 100.

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(Panmycin* Phosphate plus Albamycin*)

The broad-spectrum antibiotic of *first* resort

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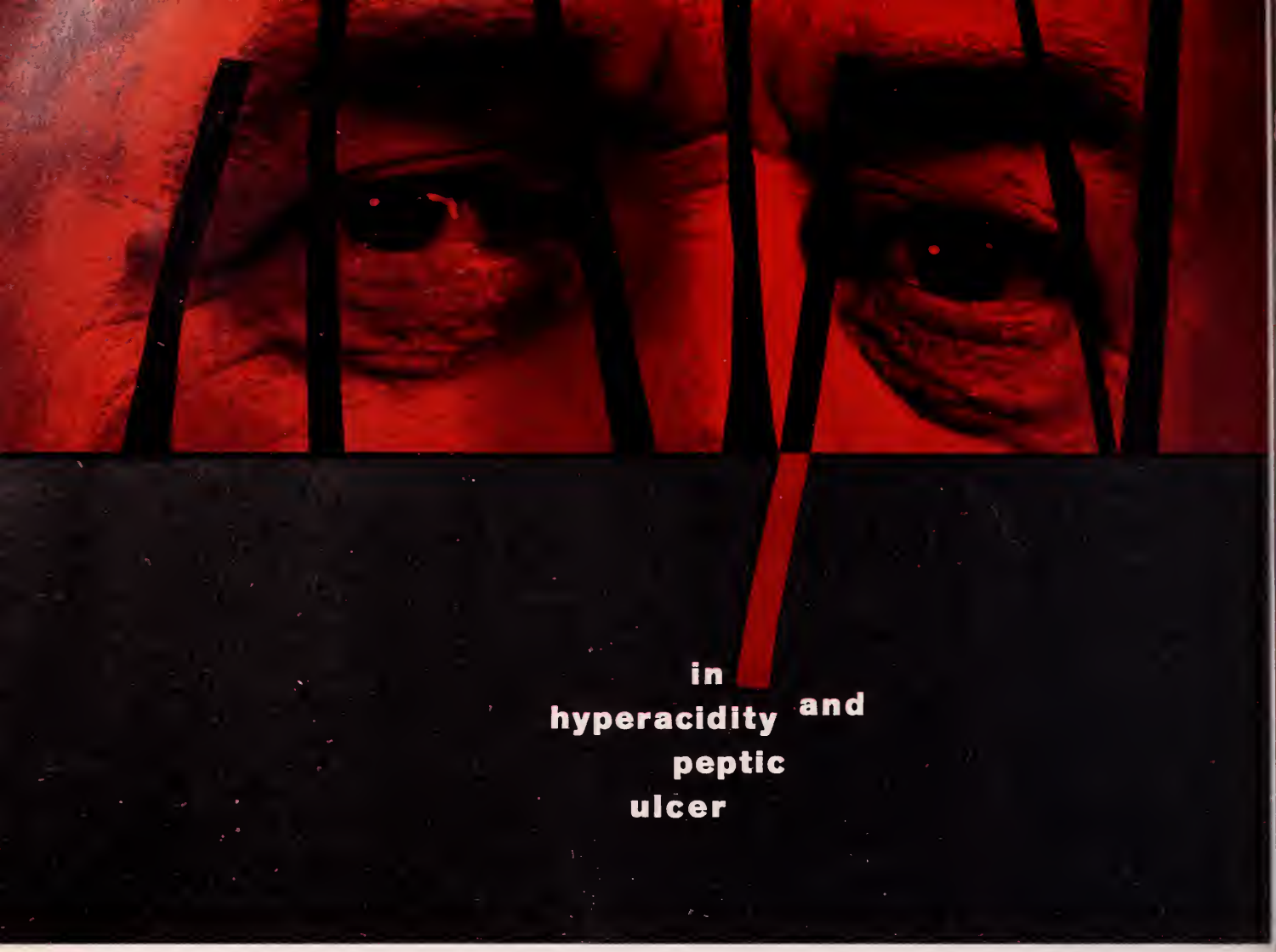

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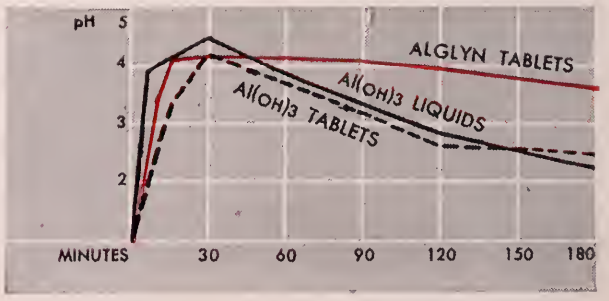
Dihydroxy aluminum aminoacetate

The superiority of Alglyn (dihydroxy aluminum aminoacetate) as an antacid over ordinary aluminum preparations is quite pronounced. Not only do Alglyn Tablets act as rapidly as aluminum hydroxide gels and magmas, but they maintain a much more effective pH for a longer time (see chart).

Furthermore, Alglyn Tablets are decidedly superior when antacid-belladonna therapy is indicated. Ordinary aluminum preparations may actually *ad*sorb as much as 80% of the spasmolytic drug, as compared to only 7% for Alglyn Tablets. In addition, Alglyn contains no sodium and less aluminum.

Supplied in bottles of 100 0.5 Gm. tablets. Also as Belglyn® (with belladonna), and as Malglyn® (with belladonna and phenobarbital). Literature available upon request.



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51 to 49...it's a boy!

94 to 6 BONADOXIN® stops morning sickness

When she asks "Doctor, what will it be?" you can either flip a coin or point out that 51.25% births are male.[1] But when she mentions morning sickness, your course is clear: BONADOXIN.

For, in a series of 766 cases of morning sickness, seven investigators report excellent to good results in 94%.[2] More than 60 million of these tiny tablets have been taken. The formula: 25 mg. Meclizine HCl (for antinauseant action) and 50 mg. Pyridoxine HCl (for metabolic replacement). Just one tablet the night before is usually enough.

BONADOXIN—DROPS and Tablets—are also effective in infant colic, motion sickness, labyrinthitis, Meniere's syndrome and for relieving the nausea and vomiting associated with anesthesia and radiation sickness. See PDR p. 795.

1. Projection from Vital Statistics, U.S. Government Dept. HEW, Vol. 48, No. 14, 1958, p. 398.
2. Modell, W.: Drugs of Choice 1958-1959, St. Louis, C. V. Mosby Company, 1958, p. 347.

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GRIP-TIGHT CAP
for Children's
Greater Protection

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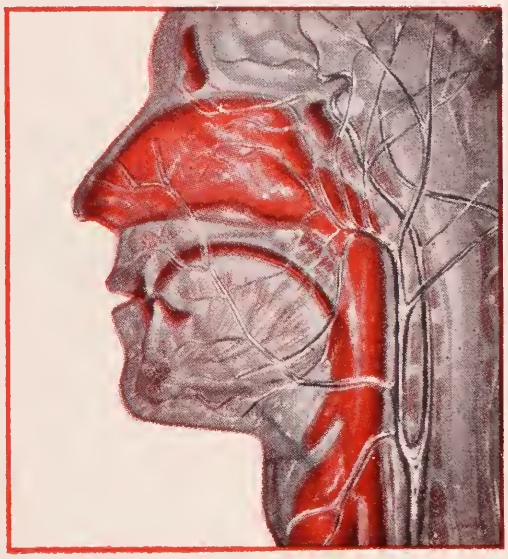
reaches all nasal and paranasal membranes *systemically*[1]



Pharmacologically balanced formula for prompt symptomatic relief

- in nasal and paranasal congestion
- in sinusitis and postnasal drip
- in allergic reactions of the upper respiratory tract

Triaminic[2,3] is safer and more effective than topical medication

- transported systemically to *all* respiratory membranes
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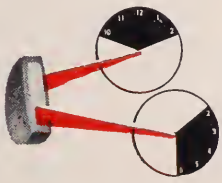
- presents no problem of rebound congestion
- avoids "nose drop addiction"

Relief is prompt and prolonged because of this special timed-release action:



first — the outer layer dissolves within minutes to produce 3 to 4 hours of relief

then — the core disintegrates to give 3 to 4 *more* hours of relief

Each Triaminic timed-release Tablet provides:
Phenylpropanolamine HCl.....50 mg.
Pheniramine maleate.....25 mg.
Pyrilamine maleate.....25 mg.

Dosage: 1 tablet in the morning, midafternoon and at bedtime. In postnasal drip, 1 tablet at bedtime is usually sufficient.

Each timed-release Triaminic Juvelet® provides: ½ the formulation of the Triaminic Tablet.

Dosage: 1 Juvelet in the morning, midafternoon and at bedtime.

Each tsp. (5 ml.) of Triaminic Syrup provides: ¼ the formulation of the Triaminic Tablet.

Dosage (to be administered every 3 or 4 hours): *Adults* — 1 or 2 tsp.; *Children 6 to 12* — 1 tsp.; *Children 1 to 6* — ½ tsp.; *Children under 1* — ¼ tsp.

1. Fabricant, N. D.: E.E.N.T. Monthly *37*:460 (July) 1958.
2. Lhotka, F. M.: Illinois M. J.: *112*:259 (Dec.) 1957.
3. Farmer, D. F.: Clin. Med. *5*:1183 (Sept.) 1958.

the leading oral nasal decongestant...

Triaminic®

timed-release tablets and juvelets
also non-alcoholic, fruit-flavored syrup

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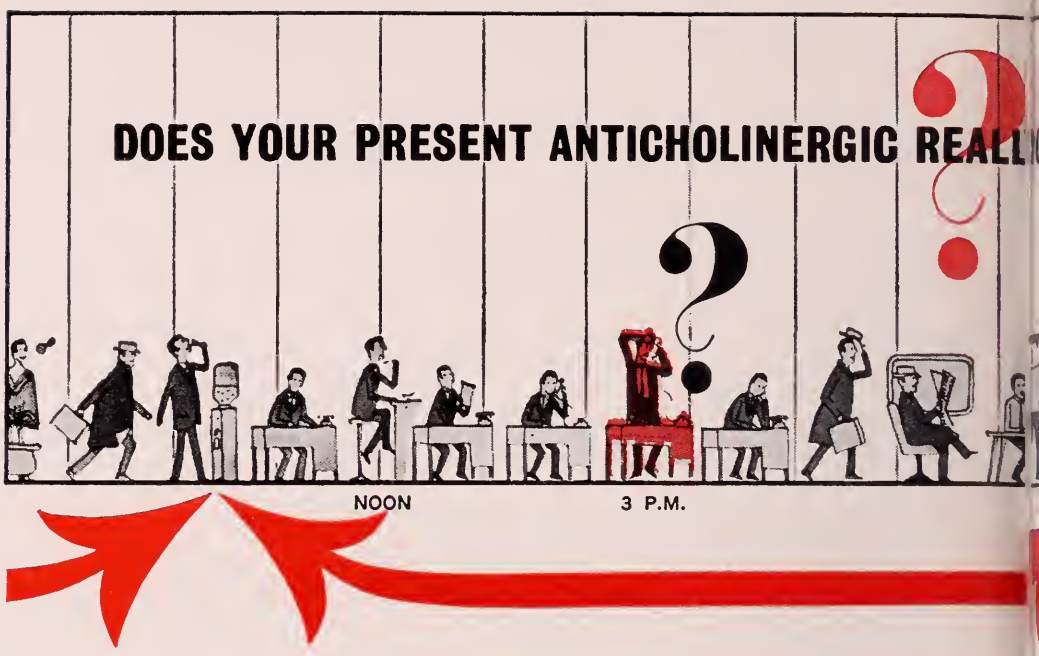


The test—you might say the acid test—of an anticholinergic is simple: will it protect your patient from hyperacidity around the clock, **even while he sleeps.** The weakness of t.i.d. or q.i.d. preparations is well recognized; but even some "b.i.d." encapsulations may be unreliable. McHardy, for instance, found a "widely variable duration of action, definitely less than that anticipated" in the "sustained," "delayed," and "gradual release" anticholinergics he studied.[1]

COMPARE THE DATA ON ENARAX . . . the new combination of an **inherently** long-acting anticholinergic (oxyphencyclimine) and Atarax, the non-secretory tranquilizer. Note the effectiveness of oxyphencyclimine:

OBSERVE THE OXYPHENCYCLIMINE REPORTS . . .

McHardy: "[Oxyphencyclimine] has proved to be an excellent sustained-action anticholinergic in our study of this agent over a period of eighteen months."[1]

Kemp: ". . . for the majority of patients, one tablet every 12 hours provided adequate control. This characteristic long action . . . may constitute an advantage of this drug as compared to coated 'long-acting' preparations of other compounds."[3]

Add Atarax to this 12-hour anticholinergic. The resulting combination—ENARAX—now gives relief from emotional stress, in addition to a reduction of spasm and acid. Atarax does not stimulate gastric secretion. No serious adverse clinical reaction has ever been documented with Atarax.

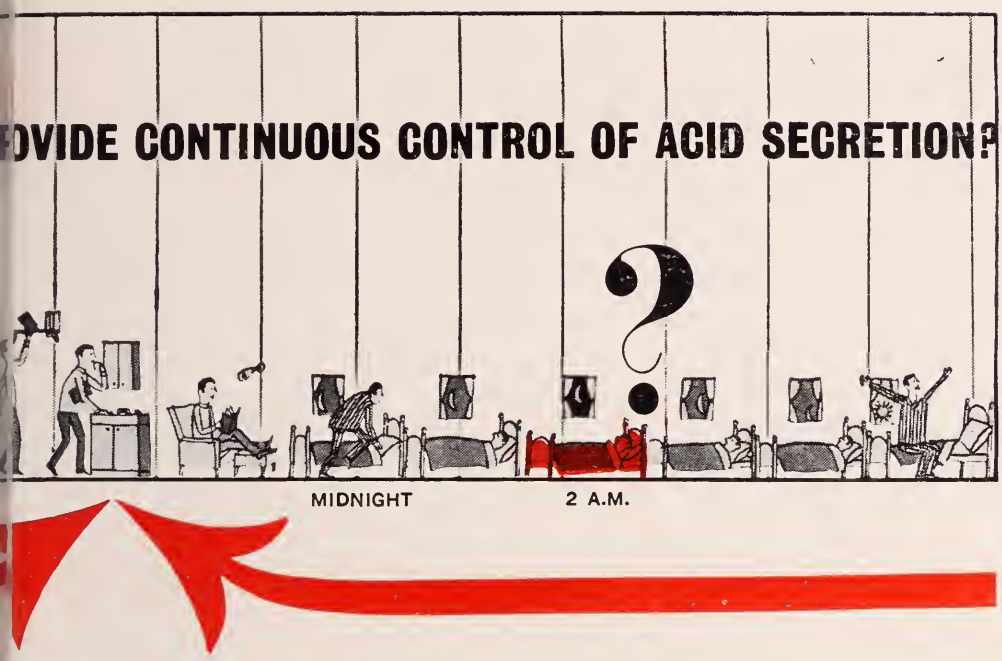
LOOK AT THE RESULTS WITH ENARAX[4,5]:

Does the medication you now prescribe assure you of all these benefits? If not, why not put your next patient with peptic ulcer or G.I. dysfunction on therapy that **does.**

ENARAX®

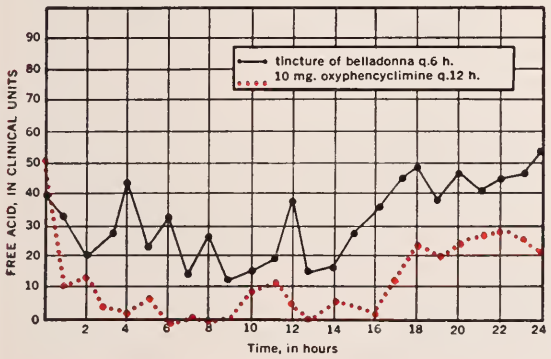
(oxyphencyclimine plus ATARAX®)

A SENTRY FOR THE G.I. TRACT



"Prolonged periods of achlorhydria" after 10 mg. oxyphencyclimine q. 12 h.[5]

MEAN GRAPH OF GASTRIC ACIDITY IN 4 PATIENTS RECEIVING COMPLETE THERAPEUTIC REGIMEN • 24-HOUR STUDY



Clinical Diagnosis: Peptic Ulcer—Gastritis—Gastroenteritis—Colitis—Functional Bowel Syndrome—Duodenitis—Hiatus Hernia (symptomatic)—Irritable Bowel Syndrome—Pylorospasm—Cardiospasm—Biliary Tract Dysfunctions—and Dysmenorrhea.

Clinical Results: Effective in over 92% of cases.

As for Safety: "Side reactions were uncommon, usually no more than dryness of the mouth...."[4]

Each ENARAX tablet contains:

Oxyphencyclimine HCl ..... 10 mg.
Hydroxyzine (ATARAX®) ..... 25 mg.

Dosage: One-half to one tablet twice daily—preferably in the morning and before retiring. The maintenance dose should be adjusted according to therapeutic response. Use with caution in patients with prostatic hypertrophy and with ophthalmological supervision only in glaucoma.

Supplied: In bottles of 60 black-and-white scored tablets.

References: 1. McHardy, G., et al.: J. Louisiana M. Soc. 111:290 (Aug.) 1959. 2. Steigmann, F.: Study conducted at Cook County Hospital, Chicago, Illinois, in press. 3. Kemp, J. A.: Antibiotic Med. & Clin. Therapy 6:534 (Sept.) 1959. 4. Leming, B. H., Jr.: Clin. Med. 6:423 (Mar.) 1959. 5. Data in Roerig Medical Department files.

ROERIG

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BOOKS RECEIVED

Navy Surgeon. By Rear Admiral Lamont Pugh (Ret.) Pp. 459. Price, $5.00. Philadelphia, J. B. Lippincott Company, 1959.

In this engaging autobiography, Lamont Pugh, ex-Surgeon General of the United States Navy, tells of his exciting, wide-ranging life in a story full of action and shrewd observation, of the sights and the sounds of world in peace and war. With affection, candor and salty wit, he tells of his boyhood in Virginia, his years in medical school, and his long distinguished naval career serving his country through three wars. He writes of outstanding cases he has treated, interesting and famous people he has known, his travels covering millions of miles to some of the remotest and most exotic spots on earth by every mode of travel from oxcart to jet airplane, world affairs, government and politics, and his own philosophy of life. More than autobiography, this unmistakably American story is a record of recent history, told by a man who has lived it.

The Plasma Proteins. CLINICAL SIGNIFICANCE. By Paul G. Weil, B.A., M.D.C.M., M.Sc., Ph.D. Pp. 133. Price, $3.50. Philadelphia, J. B. Lippincott Company 1959.

Since there has been no recent review of a general nature dealing with the plasma proteins from the clinical point of view, the author has brought together here as many of the facts as possible pertaining to them. The information has been collected from the recent as well as the older literature, interpreted in the terms of the original investigator and integrated into a form which presents the plasma proteins in their entirety. It has been the author's aim to present the subject in this manner, with constant emphasis on the relationship of the plasma proteins—both classic and of more recent discovery or interest—to health and disease. Dr. J. C. Meakins, Professor-Emeritus of Medicine, McGill University, Montreal, in the Foreword says of the author: "It was during the early days of World War II that Dr. Weil became interested in the plasma proteins and their role in shock. He was a member of the team of investigators working with me at McGill University and the Royal Victoria Hospital, and he was among the first to show clinically the importance of the plasma proteins in burn shock and that of hemorrhage in surgical shock . . . now he presents an up-to-date account of the broader aspects of this fascinating field of medicine." The book will be of value to mature clinicians, to interns and to medical students.

General Urology. By Donald R. Smith, M.D. Ed. 2. Pp. 328. Price, $4.50. Los Altos, Calif., Lange Medical Publications, 1959.

This well illustrated book, now in its second edition, is intended particularly for the medical student and medical practitioner who has not specialized in urology but whose practice requires a working familiarity with the diagnostic and therapeutic technics available for the management of the genitourinary diseases and disorders. In order to serve both groups, the author has combined both the practical and the theoretical aspects of his subject. Although many serious urologic diseases excite few, if any, symptoms, most can be discovered by a medical examination which includes a P.S.P. renal function test (which also permits estimation of residual urine, if any), simple radiographic technics, and, above all, a careful urinalysis, for a properly performed urinalysis is a most valuable clue to many urologic diagnoses. In this new edition extensive changes have been made in the chapters on Laboratory Examination, Specific Infections, Stones, Neurogenic Bladder, Intersexuality, and Renal Hypertension. Most of the x-ray illustrations have been

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Vitamin B_{12} Crystalline	25 mcgm.
Thiamine HCl (B_1)	10 mg.
Pyridoxine HCl (B_6)	5 mg.
Ferric Pyrophosphate (Soluble)	250 mg.
Iron (as Ferric Pyrophosphate)	30 mg.
Sorbitol	3.5 Gm.
Alcohol	.75%

Bottles of 4 and 16 fl. oz.

promote
protein uptake
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replaced, and many, thanks to a new reproduction process, have been vastly improved. The author is Clinical Professor of Urology and Chairman of the Department of Urology at the University of California School of Medicine in San Francisco.

Principles of Disability Evaluation. By Wilmer Cauthorn Smith, M.D. Pp. 210. Price, $7.00. Philadelphia, J. B. Lippincott Company, 1959.

It is the purpose of this volume to present and elaborate the philosophy and logic necessarily underlying any rational understanding of disability. The ability to distinguish valid disability and to evaluate it, the author points out, rests fundamentally upon a logical concept of the nature of the disability and the basic principles which govern its evaluation. If the physician grasps these fundamentals, relatively little experience will result in proficiency, and this proficiency will readily be adaptable to the provisions of any legislative enactment. This same rational understanding of the fundamentals involved will also serve to make the physician aware of the limitations necessarily imposed by medical science upon his ability to evaluate certain types of human handicaps. The subject matter of the book has four primary divisions. The introductory section deals with the growing importance of disability evaluation and the attitude of the physician toward its various facets. The second section is devoted to defining and elaborating the concept of medically ratable industrial disability. In the third section the problem of etiologic relationship between injury and disability or disease is the theme. The fourth section covers the actual evaluation of industrial disability, including a presentation and discussion of the concept and principles which must necessarily underlie a rational approach to such appraisal. The author is Chief Medical Advisor to the Oregon State Industrial Accident Commission.

Surgery of the Foot. By Henri L. DuVries, M.D. Pp. 494. Illus. 403. Price, $12.50. St. Louis, The C. V. Mosby Company, 1959.

This book has been written at the continuing request of his students and colleagues by an authority who has obligingly drawn together in one place of reference the fundamentals and the recommendations contained in his lectures and clinical demonstrations over a span of 30 years. By precept and example he set out early to enlist interest in this neglected phase of medicine and surgery; he limited his practice to the correction of disabilities of the foot, and he concentrated his teaching on that subject. As he now presents many of his observations and his practical experience in these pages, the profession can profit by observing his methods and the results of his treatment of the common disorders of the foot. This reference book should prove helpful to orthopedic surgeons, general surgeons, pediatricians, and physicians in general practice who are called upon to treat an abnormal condition of the human foot. Over 400 illustrations, including line drawings, shaded drawings, photographs, and roentgenograms, illuminate the text. The book begins with a chapter on the structure and the function of the bones of the ankle and of the muscles of the calf. The second chapter tells how to examine the human foot to make a diagnosis which will explain the cause of the patient's symptoms. Succeeding chapters cover the care of infections of the feet, burns and freezing, foreign bodies, sprains and athletic injuries, chronic circulatory ulcers associated with arteriosclerosis, tumors and cysts, disorders of the skin of the foot, deformities and injuries of the toenails, diseases of the synovia and fascia of the foot, the tendons, sesamoid bones, nerves of the foot, the bones and their articulations, fractures and dislocations, static deformities, anomalies, and congenital defects. In each instance, the procedure recommended for the treatment is described concisely but in practical detail.

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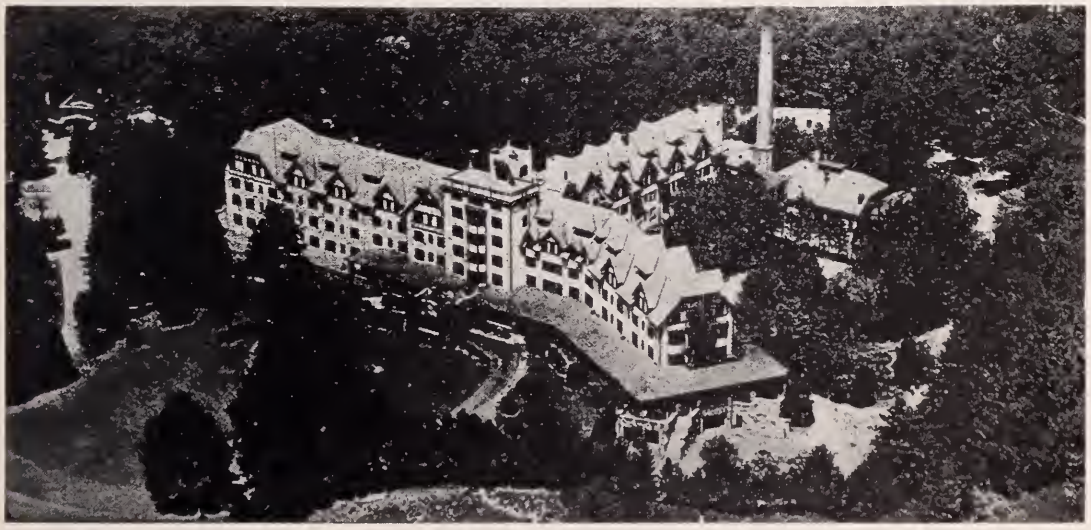

An Institution for the diagnosis and treatment of Psychiatric and Neurological illnesses, rest, convalescence, drug and alcohol habituation.

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Appalachian Hall is located in Asheville, North Carolina, a resort town, which justly claims an all around climate for health and comfort. There are ample facilities for classification of patients, rooms single or en suite.

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County Medical Societies of Florida

SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	ACTIVE MEMBERS
Alachua	Eugene H. Cummings, Gainesville	Richard E. Perry, Gainesville	2nd Tues.	68
* *Bradford, Gilchrist, Union*				
Bay	James D. Nixon, Panama City	Robert L. Overman, Panama City	2nd Tues.	34
Brevard	Cyrus E. Warden, Melbourne	John M. Gayden, Melbourne	1st Tues.	62
Broward	Anthony C. Galluccio, Hollywood	Frederick W. Fisher, Ft. Lauderdale	4th Tues.	257
Charlotte	Robert H. Shedd, Punta Gorda	Carl N. Reilly, Punta Gorda	2nd Tues.	5
Collier	Loral F. Gwaltney, Naples	Ethel H. Trygstad, Naples	4th Tues.	13
Columbia	Harry S. Howell, Lake City	Thomas H. Bates, Lake City	3rd Wed.	10
* *Baker*				
Dade	Franklin J. Evans, Coral Gables	DeWitt C. Daughtry, Miami	1st Tues.	956
DeSoto-Hardee-Glades	Harold S. Agnew, Arcadia	Elmer J. Schmierer, Arcadia	1st Tues.	13
Duval	Floyd K. Hurt, Jacksonville	Albert D. Rood, Jacksonville	1st Tues.	359
* *Clay*				
Escambia	William J. Overman, Warrington	Howard E. Herring Jr., Pensacola	2nd Tues.	117
Franklin-Gulf	Joseph P.Hendrix, Port St. Joe	Harold B. Canning, Wewahitchka	Last Wed.	6
Highlands	Hubert W. Coleman, Avon Park	Samuel A. King, Avon Park	3rd Mon.	13
Hillsborough	Linus W. Hewit, Tampa	Frank A. Massari, Tampa	1st Tues.	239
Indian River	Charles F. Rattray Jr., Vero Beach	Walter W. McCorkle, Vero Beach	2nd Tues.	12
Jackson-Calhoun	William R. Wandeck, Marianna	Francis M. Watson, Marianna	Quarterly	17
Lake	Arthur P. Buchanan, Leesburg	Thomas D. Weaver, Clermont	1st Wed.	34
* *Sumter*				
Lee-Hendry	George D. Hopkins II, Ft. Myers	Leland K. Glenn, Ft. Myers	3rd Mon.	37
Leon-Gadsden-Liberty-Wakulla-Jefferson	Edson J. Andrews, Tallahassee	David J. McCulloch, Tallahassee	1st Mon.	74
Madison	A. Franklin Harrison, Madison	Thomas G. Bouland Jr., Madison	1st Tues.	8
Manatee	Irving E. Hall Jr. Bradenton	Joseph E. Duke, Bradenton	2nd Tues.	36
Marion	Earl E. Yantis, Ocala	Wallace E. Winter, Ocala	3rd Tues.	33
* *Levy*				
Monroe	Walter R. McCook, Key West	Joseph L. G. Lester Jr., Key West	1st Thurs.	16
Nassau	David D. Bennett Jr., Callahan	Cecil B. Brewton, Fernandina Beach	1st Thurs.	6
Orange	W. Dean Steward, Orlando	Robert W. Curry, Orlando	3rd Wed.	251
* *Osceola*				
Palm Beach	Younger A. Staton, W. Palm Beach	Herman Baxt, W. Palm Beach	4th Mon.	181
Pasco-Hernando-Citrus	William H. Walters Jr., Lacoochee	W. Wardlaw Jones, Dade City	2nd Thurs.	18
Pinellas	Chas. L. Farrington, St. Petersburg	Whitman C. McConnell, St. Petersburg	1st Mon.	301
Polk	Charles Larsen Jr.,Lakeland	Clarence L. Anderson, Lakeland	2nd Wed.	128
Putnam	Charles E. Barrineau, Palatka	James C. Kitaif, Palatka	2nd Tues.	14
St. Johns	William J. Gibson, St. Augustine	Joseph A. Shelley, St. Augustine	3rd Tues.	18
St. Lucie-Okeechobee-Martin	Joseph H. Batsche, Fort Pierce	Maltby F. Watkins, Ft. Pierce	3rd Thurs.	29
Sarasota	James E. Kicklighter, Sarasota	Thomas G. Dickinson, Sarasota	2nd Tues.	89
Seminole	Vann Parker, Sanford	Robert M. Rosemond, Sanford	2nd Tues.	18
Suwannee-Hamilton-Lafayette	Frederick T. Mickler Jr., Jasper	Irby H. Black, Live Oak	1st Sat.	10
Taylor	John H. Parker Jr., Perry	John A. Dyal Jr., Perry	Last Fri.	6
* *Dixie*				
Volusia	Jas. J. Cunningham, New Smyrna Bch.	John J. Cheleden, Daytona Beach	2nd Tues.	101
* *Flager*				
Walton-Okaloosa-Santa Rosa	Joseph C. Wilson, Ft. Walton Beach	Wm. W. Thompson, Ft. Walton Beach	3rd Tues.	31
Washington-Holmes	Walter H. Shehee, Chipley	L. H. Paul, Bonifay	Quarterly	5
			Total	3,625

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*Source: Traisman, H. S.; Boehm, J. J., and Newcomb, A. L.: Diabetes *8*:289, 1959.

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Order of Frequency of Presenting Symptoms in 110 Patients

Symptoms	No. of Patients	Per cent of total group
Polyuria	93	84.5
Polydipsia	89	81.0
Weight loss	47	42.7
Polyphagia	28	25.4
Anorexia	16	14.5
Lethargy	14	12.7
Enuresis	7	6.4
Vomiting	5	4.5
Irritability	3	2.7
"Craving for sweets"	3	2.7
"Sticky diaper"	3	2.7
"Strong odor to urine"	2	1.8
Glycosuria	2	1.8
Hypoglycemia	2	1.8
Personality change	1	0.9
Boils	1	0.9
Headache	1	0.9
Abdominal cramps	1	0.9

Adapted from Traisman, H. S.; Boehm, J. J., and Newcomb, A. L.*

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1. Goddard, E.S.: in *Trifluoperazine, Further Clinical and Laboratory Studies*, Philadelphia, Lea & Febiger, 1959.

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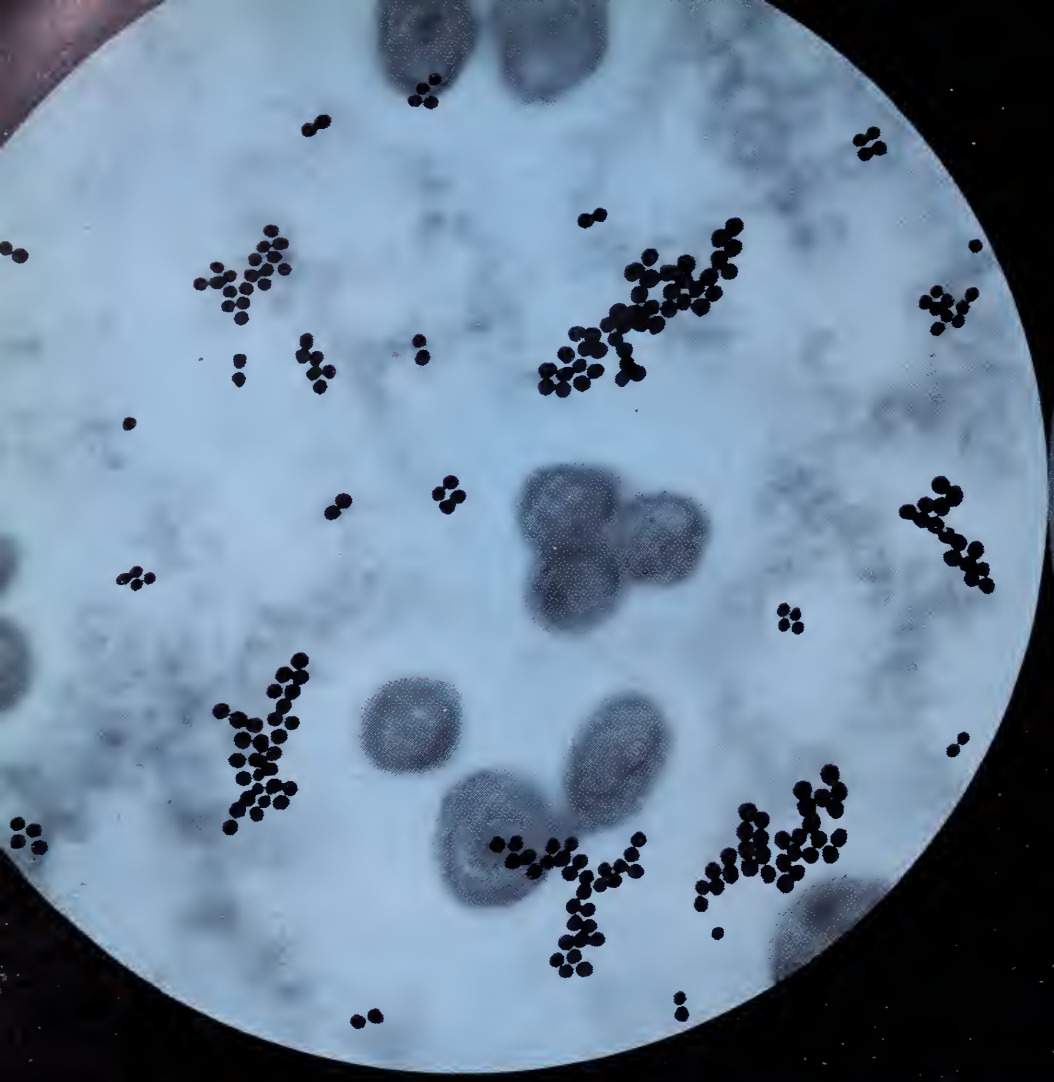

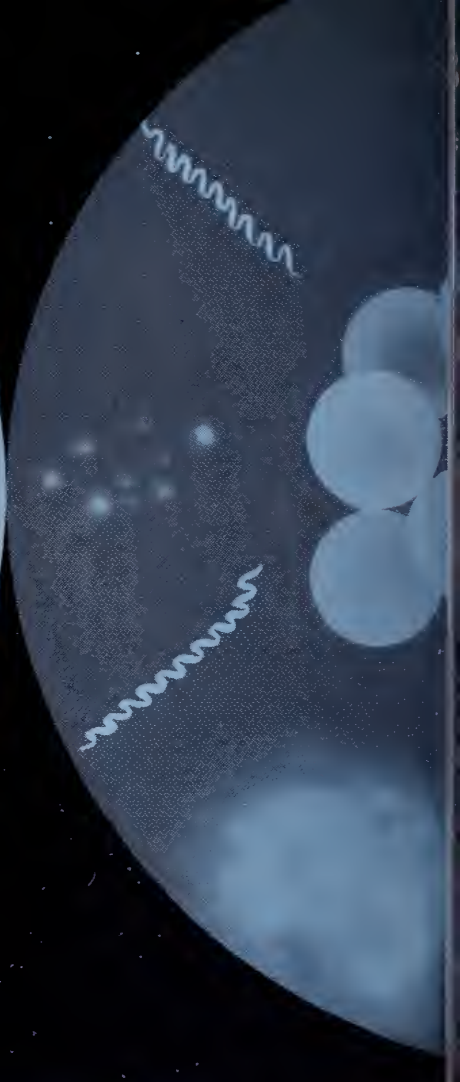

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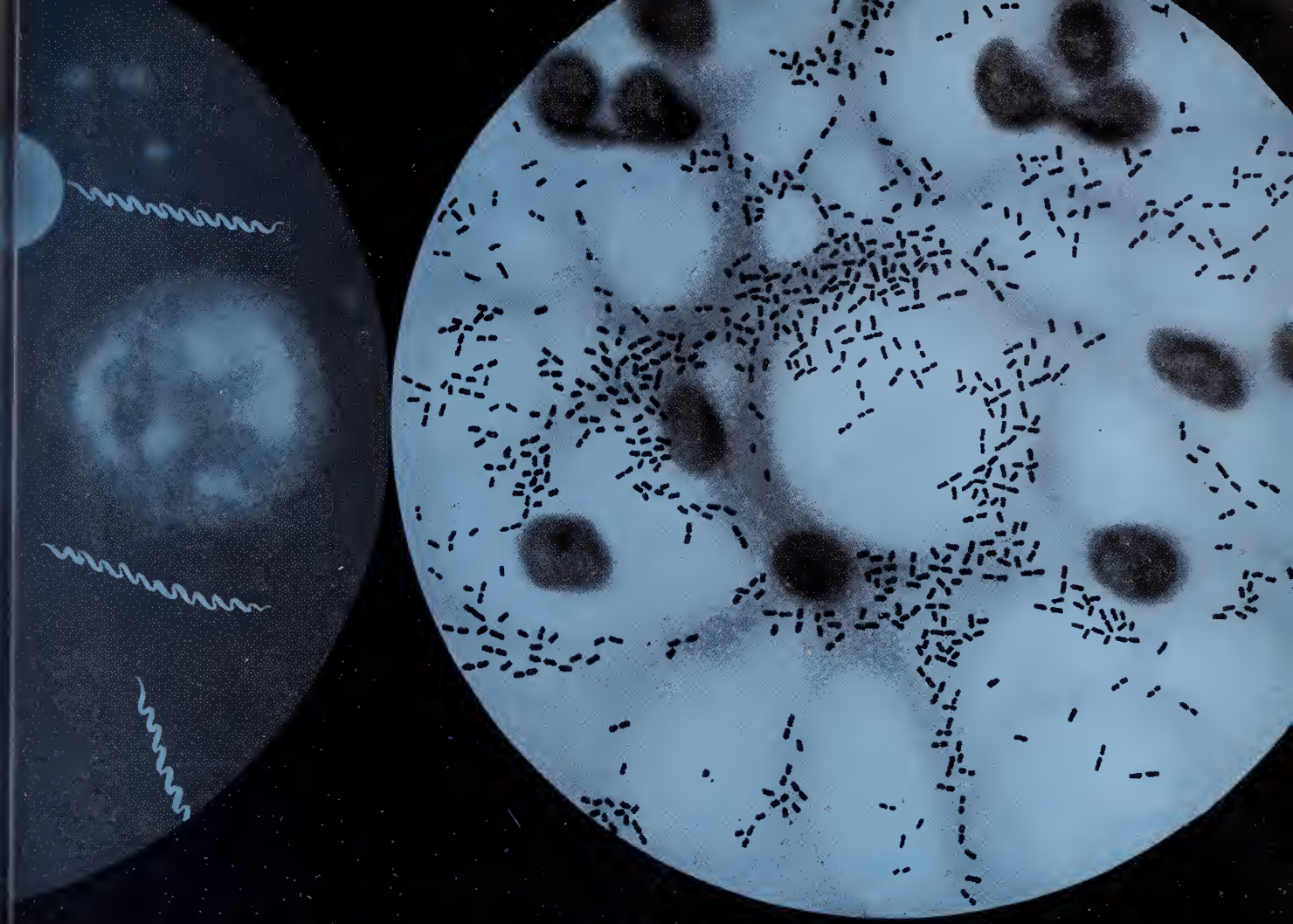
IN VITRO SENSITIVITY OF GRAM-POSITIVE ORGANISMS TO CHLOROMYCETIN AI TO THREE OTHER BROAD-SPECTRUM ANTIBIOTICS*

*Adapted from Leming & Flanigan.[3]



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rences: (1) Morton, J. J.: *Yale J. Biol. & Med.* **31**:397, 1959. (2) Rogers, D. E., & Louria, D. B.: *New England J. Med.* **261**:86, 1959. Leming, B. H., Jr., & Flanigan, C., Jr., in Welch, H., & Marti-Ibañez, F.: Antibiotics Annual 1958-1959, New York, Medical Encyclo- a, Inc., 1959, p. 414. (4) Edwards, T. S.: *Am. J. Ophth.* **48**:19, 1959. (5) Olarte, J., & de la Torre, J. A.: *Am. J. Trop. Med.* **18**:324, 1959. uter, L. S., & Ulrich, E. W.: *Antibiotics & Chemother.* **9**:38, 1959. (7) Holloway, W. J., & Scott, E. G.: *Delaware M. J.* **30**:175, 1958.

VITRO SENSITIVITY OF GRAM-NEGATIVE ORGANISMS TO CHLOROMYCETIN AND TO THREE OTHER BROAD-SPECTRUM ANTIBIOTICS*

HLOROMYCETIN (244 strains)	62%
NTIBIOTIC A (245 strains)	46%
NTIBIOTIC B (237 strains)	55%
NTIBIOTIC C (236 strains)	50%

*Adapted from Leming & Flanigan.[9]

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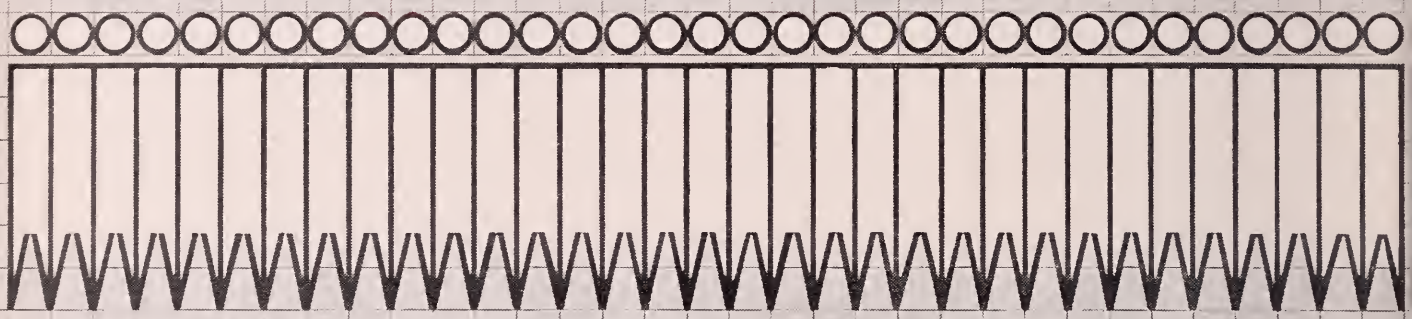
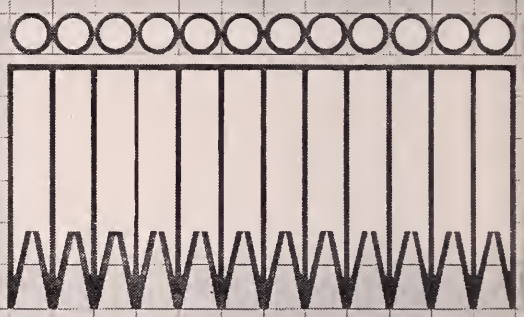
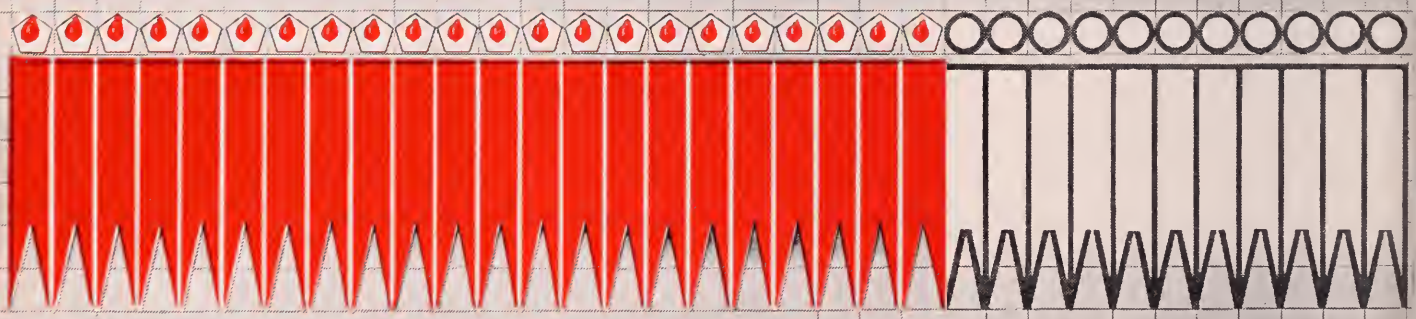


Of 45 arthritic patients
who were refractory
to other corticosteroids*





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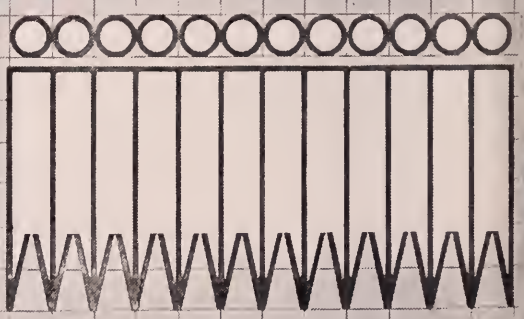

1. Boland, E. W., and Headley, N. E.: Paper read before the Am. Rheum. Assoc., San Francisco, Calif., June 21, 1958.
2. Bunim, J. J., et al.: Paper read before the Am. Rheum. Assoc., San Francisco, Calif., June 21, 1958.

*Cortisone, prednisone and prednisolone.

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April, 1960

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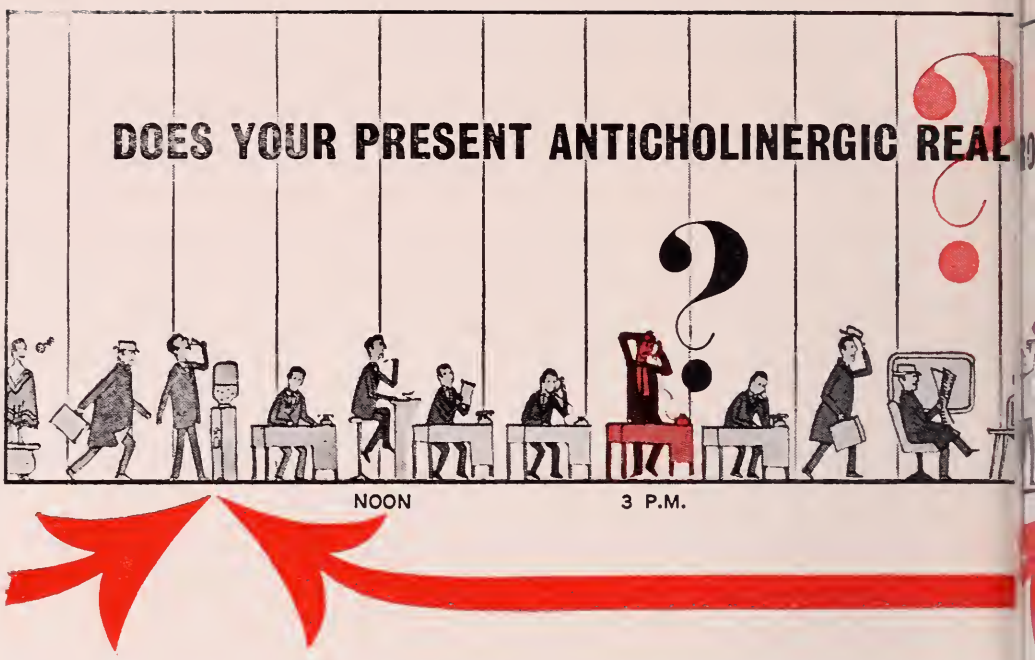

The test—you might say the acid test—of an anticholinergic is simple: will it protect your patient from hyperacidity around the clock, **even while he sleeps.** The weakness of t.i.d. or q.i.d. preparations is well recognized; but even some "b.i.d." encapsulations may be unreliable. McHardy, for instance, found a "widely variable duration of action, definitely less than that anticipated" in the "sustained," "delayed," and "gradual release" anticholinergics he studied.[1]

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McHardy: "[Oxyphencyclimine] has proved to be an excellent sustained-action anticholinergic in our study of this agent over a period of eighteen months."[1]

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Add Atarax to this 12-hour anticholinergic. The resulting combination—ENARAX—now gives relief from emotional stress, in addition to a reduction of spasm and acid. Atarax does not stimulate gastric secretion. No serious adverse clinical reaction has ever been documented with Atarax.

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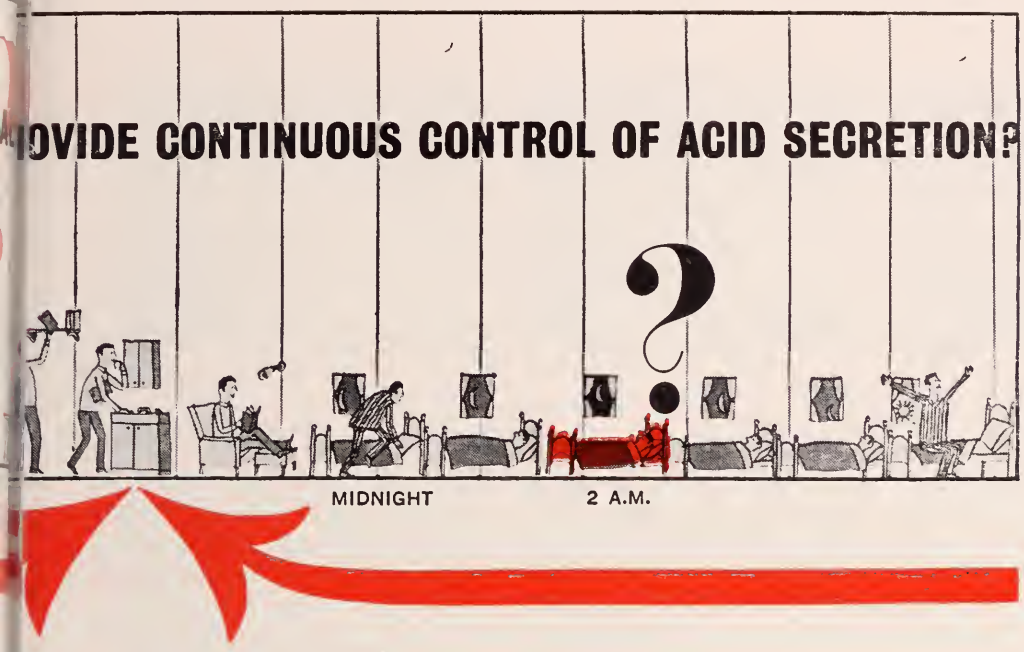

"Prolonged periods of achlorhydria" after 10 mg. oxyphencyclimine q. 12 h.[3]

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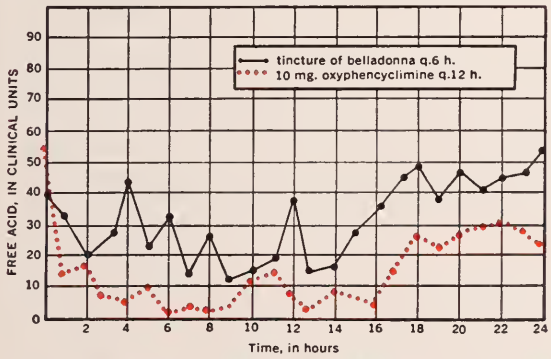

Clinical Diagnosis: Peptic Ulcer—Gastritis—Gastroenteritis—Colitis—Functional Bowel Syndrome—Duodenitis—Hiatus Hernia (symptomatic)—Irritable Bowel Syndrome—Pylorospasm—Cardiospasm—Biliary Tract Dysfunctions—and Dysmenorrhea.

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References: 1. McHardy, G., et al.: J. Louisiana M. Soc. 111:290 (Aug.) 1959. 2. Steigmann, F.: Study conducted at Cook County Hospital, Chicago, Illinois, in press. 3. Kemp, J. A.: Antibiotic Med. & Clin. Therapy 6:534 (Sept.) 1959. 4. Leming, B. H., Jr.: Clin. Med. 6:423 (Mar.) 1959. 5. Data in Roerig Medical Department files.

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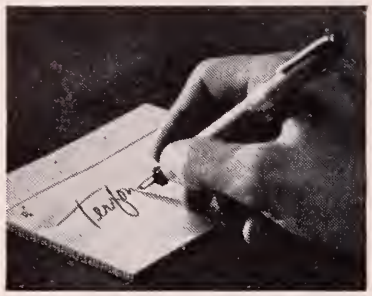
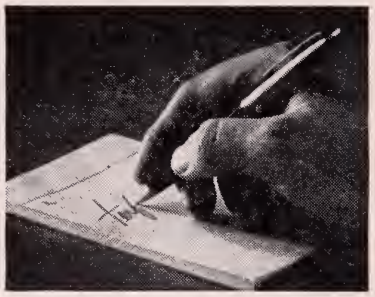
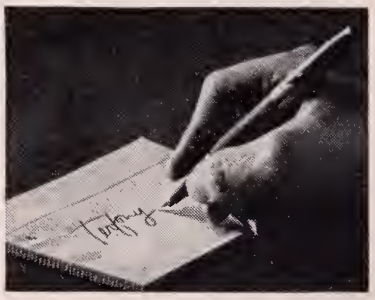

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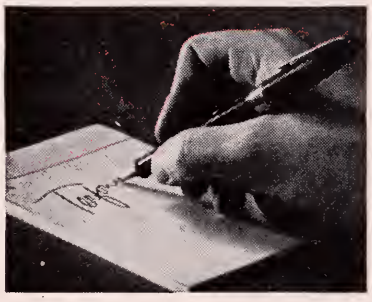
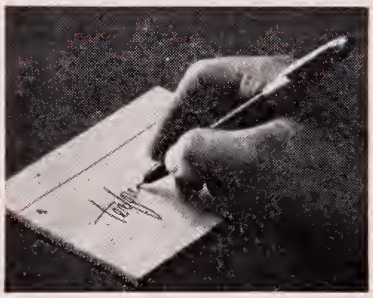

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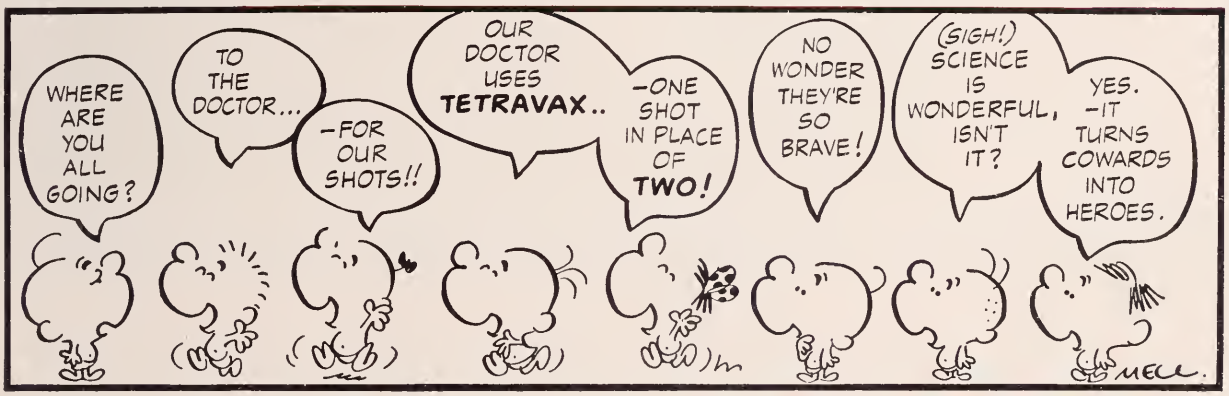

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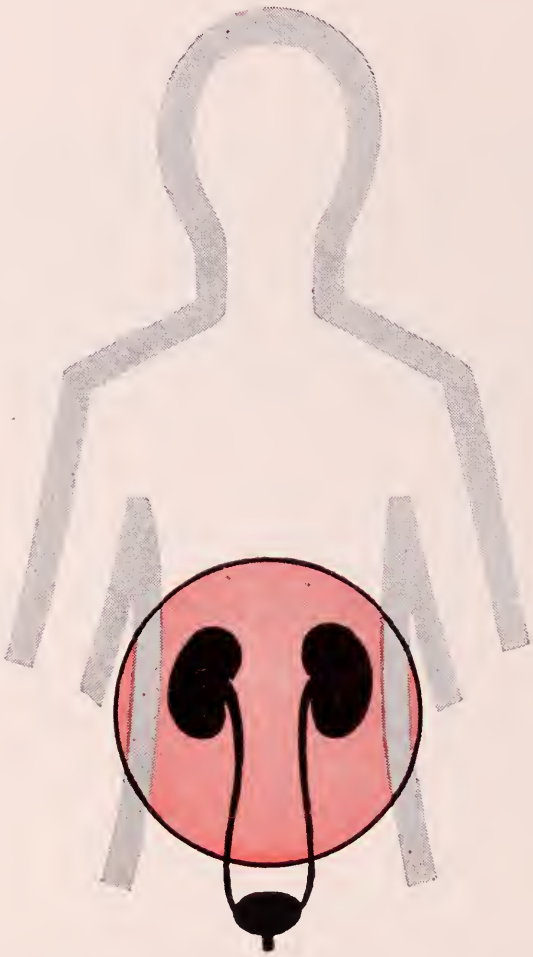

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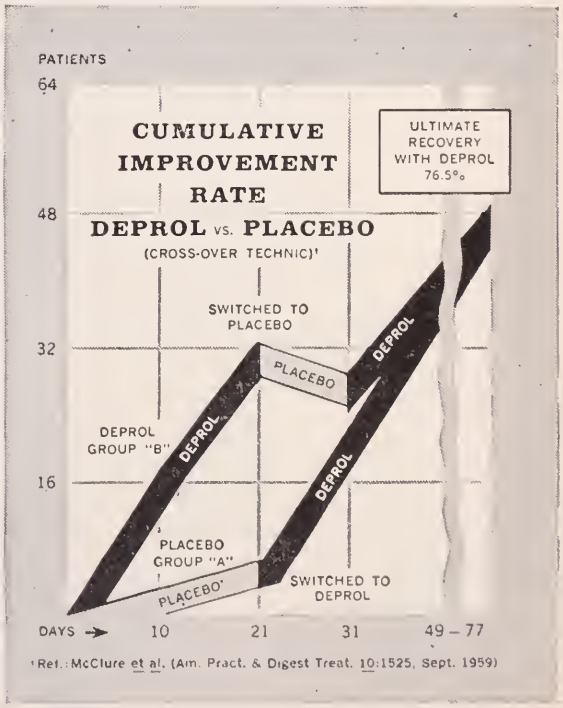

[1] Ref.: McClure et al. (Am. Pract. & Digest Treat. 10:1525, Sept. 1959)

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Rheumatoid Arthritis? Regional Enteritis?

A DISEASE that is frequently overlooked in solving diagnostic quandaries is amebiasis. Its symptoms are varied and contradictory, and diagnosis is extremely difficult. In one study, 56% of the cases would have been overlooked if the routine three stool specimens had been relied on.[1]

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Write for descriptive literature, bibliography, and dosage schedules.

1. Cook, J.E., Briggs, G.W., and Hindley, F.W.: Chronic Amebiasis and the Need for a Diagnostic Profile, Am. Pract. and Dig. of Treat. *6*:1821 (Dec., 1955).

2. Rinehart, R.E., and Marcus, H.: Incidence of Amebiasis in Healthy Individuals, Clinic Patients and Those with Rheumatoid Arthritis, Northwest Med., *54*:708 (July, 1955).

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*U.S. Pat. No. 2,864,745

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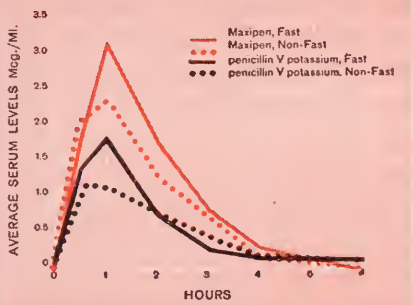

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1. Smith, I. M., and Soderstrom, W. H.: J. A. M. A., *170*:184 (May 9), 1959.

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THE JOURNAL
OF THE
FLORIDA MEDICAL ASSOCIATION

Volume XLVI, No. 10, April, 1960

Experimental and Clinical Use Of Intravenous Fibrinolysin Therapy

PAUL W. BOYLES, M.D.
MIAMI

Fibrinolysin is a naturally occurring enzyme of the blood. It is normally present in an inactive form called profibrinolysin, which can be activated by several different agents, including streptokinase. Injections of purified streptokinase induce a fibrinolytic mechanism in man which dissolves fibrin clots.[1] Systemic reactions, however, such as chills, fever, and shock occur following the administration of streptokinase. Inhibitors in the circulating blood against streptokinase may be responsible for the systemic reactions.

Intravenous infusion of active fibrinolysin is another method for inducing fibrinolytic activity. Technical advances in the purification of human profibrinolysin, which is activated with relatively small amounts of streptokinase, provide a preparation of active fibrinolysin. The objective evaluation of intravenous fibrinolysin therapy on experimental blood clots and preliminary application in patients with thromboembolic diseases is presented in this paper.

Methods

Radio-opaque blood clots were produced in leg veins and in coronary arteries of dogs by methods which I have previously described.[2-4] The fate of the clots was determined by serial x-ray examinations in both control and treated animals.

Results

1. IN VIVO EFFECTS OF INTRAVENOUS FIBRINOLYSIN.—The effects of a rapid infusion of human fibrinolysin on the various coagulation tests are illustrated in figure 1. The most striking effects are reduction of prothrombin consumption and fibrinogen and an increase in fibrinolytic activity. These changes usually revert back to normal within 24 hours in the average dog.

2. EFFECTS OF INTRAVENOUS FIBRINOLYSIN THERAPY ON RADIO-OPAQUE CLOTS.—Radio-opaque blood clots were produced in the leg veins of dogs by injecting a mixture of thromboplastin and radio-opaque material into a temporarily occluded vein segment. The fate of the resulting radio-opaque clot was subsequently determined by x-ray examination. The x-ray appearance of such a clot is presented in figure 2. Intravenous administration of a single injection of 200,000 units of fibrinolysin dissolved these clots in seven dogs within 24 hours, whereas the control clots required a period of from five to seven days to dissolve.

A similar technic was used to produce radio-opaque coronary thrombi in dogs. Intravenous fibrinolysin therapy in doses between 400,000 and 1,350,000 units given within one-half to one hour after the formation of the clots did not significantly accelerate the lysis of these clots. X-rays from one treated dog are illustrated in figure 3. The coronary thrombi in both the control and treated animals dissolved in six to 10 days after the formation of the clot. More recent experiments have indicated a rapid lysis for these coronary thrombi by administering fibrinolysin into the root of the aorta during the diastolic phase of the cardiac cycle.

From the Coagulation Research Laboratory, Miami Heart Institute, and the Department of Medicine, University of Miami School of Medicine.
Read before the Florida Medical Association, Eighty-Fifth Annual Meeting, Bal Harbour, Miami Beach, May 5, 1959.

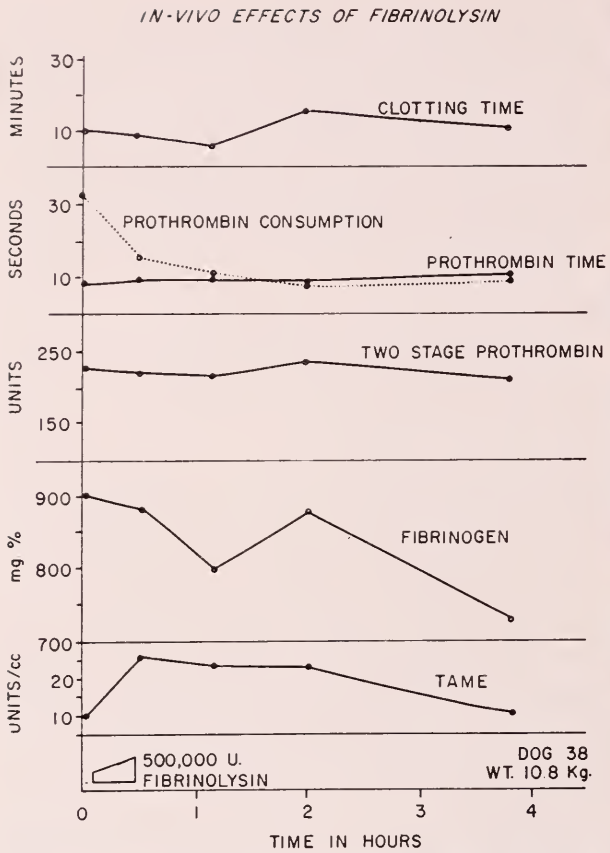

Fig. 1.—Effect of intravenous fibrinolysin administration on the various coagulation factors.

Fig. 2.—X-ray of radio-opaque blood clot in dog vein one hour after clot formation and prior to the systemic injection of fibrinolysin.

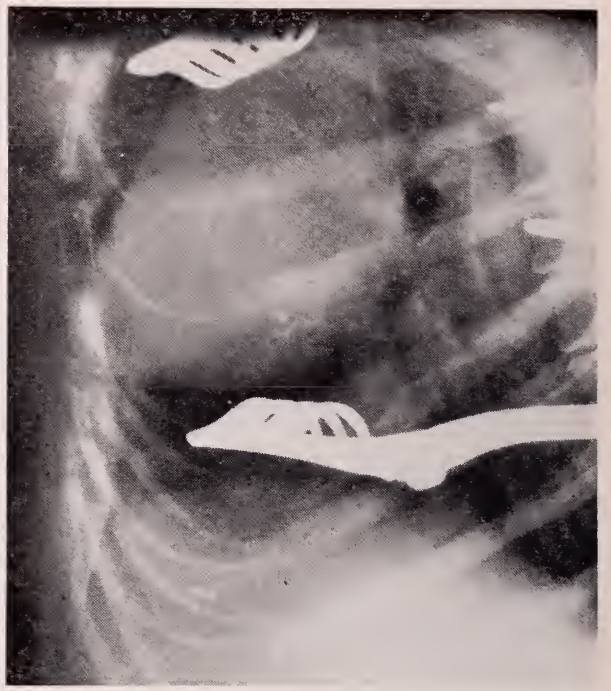

Fig. 3.—Serial x-rays from a dog with a radio-opaque coronary thrombus: (A) at the time of surgery, (B) one hour after clot formation and prior to the infusion of fibrinolysin, (C) two hours after the fibrinolysin therapy, and (D) four hours after the fibrinolysin therapy.

3. Preliminary Observations of Intravenous Fibrinolysin Therapy in Patients.—In 11 patients with various thrombotic episodes 19 infusions were administered in doses between 100,000 and 300,000 units dissolved in 200 ml. of 5 per cent dextrose and saline. In four of these patients treatment was started within 72 hours after the onset of symptoms. In these patients there was good clinical evidence that the occluded vessels became patent within 24 hours after therapy was instituted. In three patients who were treated later than three days after the onset of symptoms, no significant clinical improvement was noted. The remaining four patients died shortly after therapy was started, and the response could not be evaluated. Concurrent anticoagulant therapy was used in all but one patient. In no instance was hemorrhage noted. Fifty per cent of the patients exhibited some type of systemic reaction. The most common reactions were chills and fever. In one patient hypotension developed after the first infusion, which required treatment, and subsequent studies revealed the presence of antibodies in his blood against both streptokinase and fibrinolysin.[5] A transient erythematous rash developed in one patient on the sixth day after starting therapy. The effects of the repeated injections of fibrinolysin in this patient are il-

Figure 3(B).

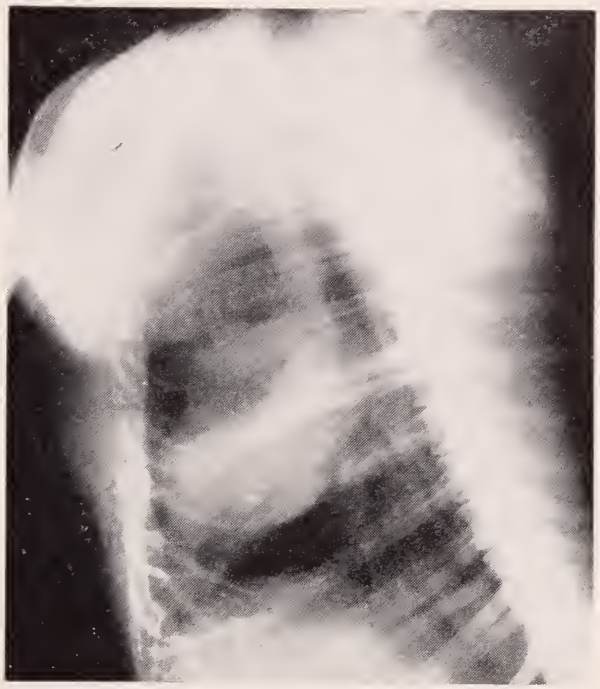

Figure 3(D).

Figure 3(C).

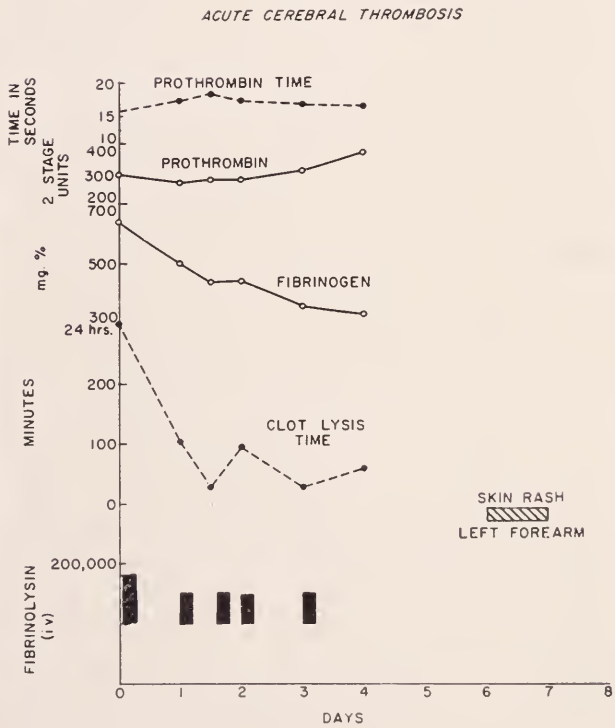

Fig. 4.—Serial blood studies of a patient treated with five intravenous infusions of human fibrinolysin.

lustrated in figure 4. The most striking changes were elevation in the circulating level of fibrinolytic activity, and decrease in the level of fibrinogen. These systemic reactions have decreased by prolonging the time of the infusion from 30 minutes to four hours. No attempt was

made to ameliorate these reactions with antipyretics or antihistamines, which would probably reduce the incidence of systemic effects.

Summary

Intravenous fibrinolysin therapy is effective in dissolving venous blood clots. Arterial thrombi are effectively treated with segmental injection of interarterial fibrinolysin. Preliminary observations in patients are encouraging when fibrinolysin therapy is initiated within three days after the onset of symptoms. Systemic reactions have occurred rather frequently after rapid infusions and less frequently after slow, prolonged intravenous administration. The systemic reactions, which in many respects are similar to those encountered with streptokinase, emphasize the need for further study.

Human Fibrinolysin (Actase) used in these studies was supplied by Drs. Singher and Chapple, Ortho Research Foundation, Raritan, N. J.

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University of Miami School of Medicine.

Discussion

DR. GEORGE T. HARRELL, Gainesville: The treatment of thrombosis of blood vessels is a problem of prime importance to Florida physicians. The increasing age of our population makes our people more susceptible to the development of clots in the vessels. The frequency of venous involvement, particularly peripheral thrombophlebitis, has been well recognized for years. The danger in venous thrombi lies in the pulmonary emboli which frequently follow and often are fatal. In Florida arterial thrombi also present a particularly difficult and frequent therapeutic problem. In the case of peripheral occlusion a surgical approach can be made, but in the more frequent coronary and cerebral thromboses few effective measures have been devised. Dr. Boyles' experience parallels that of others in that venous thromboses are more readily attacked than are arterial ones.

In attempting to evaluate data in any new therapeutic approach one must first be familiar with the natural history of the disease. The results reported reflect the collateral circulation which is available. The large number of anastomoses between veins give ready access by the enzyme to the clots. The meager collateral circulation in the coronary and cerebral arterial systems is the reason for the use of intra-arterial injections in these areas. In the normal course of events thrombi will begin to recanalize. I wonder if Dr. Boyles has made sections of his control animals to see if the clots have dissolved at eight days or whether they have organized and begun to form a new channel. The age of the clot is apparently a factor of prime importance in anticipating a favorable result. The experience of Dr. Boyles parallels that of others; little effect is achieved if treatment is started after the third day. The experiments in animals cannot be extrapolated to the treatment of many cases in human beings. Very rarely does the physician see the patient within one hour after the formation of the acute clot, and the difficulty in diagnosis of a thrombus this early in the course of the disease is familiar to us all. The experience of all workers in this field indicates that acute thrombi lyse more readily than do chronic ones.

Various investigators have used a series of lytic agents. Some years ago in another state we tried early preparations of trypsin of animal origin, but found the material relatively ineffective and its use was accompanied by rather severe side reactions. Streptokinase has been used as a lysing enzyme. This material is also derived from a foreign source; in many persons antibodies to it develop as a result of repeated streptococcal infections. The rash as well as the more severe reactions with chills, drop in blood pressure and other evidence of anaphylactic phenomena are undoubtedly the result of antigen-antibody reactions in the blood. On theoretic grounds fibrinolysin should be the preparation of choice. The material can be derived from either human or bovine serums. In spite of the fact that the human material should not contain foreign antibodies, reactions have occurred in 50 per cent of human patients after its use, and the experience of Dr. Boyles parallels that of others. Should better means of processing be found to reduce these side reactions, it still may not be possible to obtain as much material of human origin as necessary. It is fortunate that a bovine source is available since experience with antiserums in infectious diseases indicates that this species produces relatively few reactions. An excellent review of research methods for studies in this field has recently been published (Annals New York Academy of Science 68:97, 1957.)

The experiments reported by Dr. Boyles indicate the need for dependable laboratory determination of clotting factors in order to control therapy. The recommendation that anticoagulant therapy be simultaneously administered is in keeping with the conclusions of other workers in the field. The difficulty in achieving an effective concentration of enzyme at the site as shown by the animal experiments has wisely led Dr. Boyles not to attempt treatment of coronary thrombosis in human beings at this time.

It should most forceably be pointed out that this paper demonstrates well that good research with an experimental approach can be accomplished by a physician who is primarily in private practice.

Some Common Orthopedic Problems In Industry

George F. Wilkins, M.D.
BOSTON, MASS.

Just 25 years ago, I had the privilege of spending a year at the Riverside Hospital in Jacksonville under the tutelage of Dr. Edward Jelks and the late Dr. Harry A. Peyton. This was during the depression, and in Florida there was no tourist trade to speak of; there was little if any industry; and the economy of the state was almost entirely agricultural. Since that time, the tremendous growth of Florida with the influx of industry of all types has served to convert much of the economy from an agricultural to an industrial one. Thus many, if not most, physicians of this state now have some contact with industrial medical problems, either in the treatment of employees as private patients or in providing medical services of various types to industry on some sort of a regular arrangement basis.

Since I was advised that the majority of this audience either specializes in or has a special interest in Orthopedics and/or Trauma, it seemed appropriate for me to select subjects in this field, though not being an orthopedist myself, I approached the assignment with some trepidation. I thought, however, that you might be interested in a few problems with which the Medical Department of a large industry is periodically or regularly confronted.

Knee Injuries

Injuries of the knee can present difficulties both from the point of determining compensation liability and in rehabilitation. Since the knee joint is supported by a good capsule and reasonably strong ligaments, one would expect a fair amount of stress to be necessary to produce semilunar cartilage injury—that is, a sudden forced twisting movement of the knee with the foot fixed, such as occurs in a fall while skiing, for example. It is true that in most instances a definite history of suddenly unusual trauma is obtained. This is not always the case, however, as can be attested by anyone who sees knee injuries of this type in any volume.

Most of our Telephone Plant craftsmen do some climbing as a part of their regular duties. Also when installing phones or running and repairing cable, they may work in a squatting position for varying periods of time. It is surprising how frequently we see cases of internal derangement of the knee, allegedly incurred merely in stepping to the ground from the bottom rung of a ladder or arising from a squatting position without any history of definite or recognized twist, slip, fall, or other untoward incident. Furthermore, the patients almost always are young men in their twenties or early thirties with good general muscular development.

In the absence of any apparent unusual event occurring during the work operation, the question always arises as to whether this is or is not an industrial and compensable condition. If subsequent investigation discloses no history or record of prior knee injury, and most of them do not, the case usually is accepted as a new injury arising out of and during the course of employment. This acceptance results in great unhappiness among the safety and accident prevention people since they believe they are being charged with a lost time accident when, in their eyes at least, there actually was no accident, and they usually blame the industrial physician for this additional blot on their safety record.

The problem in rehabilitation of knee injuries relates almost exclusively to the nonindustrial case. The industrial injury almost always comes to the prompt attention of the plant physician, who either institutes treatment himself or directs the patient to the care of an orthopedist. The nonindustrial patient, however, usually is treated during the acute phase by his personal physician and ordinarily is not seen at the plant Medical Department until anywhere from two to several weeks later for evaluation of ability to return to work. By this time the joint effusion has sub-

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Read before the Florida Association of Industrial and Railway Surgeons and the Florida Orthopedic Society, Bal Harbour, Miami Beach, May 2, 1959.

sided, the ligaments have healed, and if the semilunar cartilage has not been injured, the knee itself has returned to an essentially normal state. The patient, however, is still disabled because of atrophy and weakness of the quadriceps group. As you all know, measurable loss of tone of this muscle group has been demonstrated as early as six hours following trauma to the knee joint, apparently as the result of unfavorable reflex stimuli from the site of injury. In our experience it is rare indeed for the physician other than an orthopedist or surgeon commonly dealing with trauma to pay much attention to the quadriceps. Consequently, quadriceps setting exercises usually are not introduced so that with immobilization of the knee, the atrophy and loss of tone rapidly progress, and of course subsequent walking or standing fails to provide much exercise for the quadriceps group. Neither does heat, massage, or passive manipulation accomplish anything substantial in the restoration of tone and muscle mass. Consequently, in this type of case active muscle setting exercises against resistance must be undertaken, but since they have been started many weeks too late, the disability for work is unnecessarily prolonged.

Cervical Radiculitis

Another condition that I should like to discuss for a few moments is that of cervical radiculitis secondary to degenerative changes in the cervical spine and the relative frequency with which it is unrecognized. Symptoms, of course, vary from patient to patient, but they are sufficient to produce disability for work in a substantial number of cases.

When symptoms occur in the cervical region, ordinarily no diagnostic problem is involved since failure to respond quickly to local heat and analgesics usually results in an x-ray of the cervical region being obtained and the diagnosis established. As with many other types of inflammatory processes, however, pain may be referred to areas other than the site of the lesion—in this instance, to the upper extremity. In many cases, even with referred pain, a careful history and examination will immediately lead one to suspect the proper diagnosis. The burning character of the pain, its intensification at night as a result of the reclining position, and the presence of sensory disturbances in one or more fingers are common and are typical of this condition.

In our experience, however, there are a substantial number of cases in which pain is referred to and symptomatically limited to the shoulder area. Here one is apt to consider the condition as subacromial or subdeltoid bursitis and treat the patient accordingly, of course, with failure to respond and with prolongation of symptoms and disability.

Figure 1.

The patient whose x-ray is shown in figure 1 is a 51 year old executive. In 1951 at age 43, he experienced pain localized to the right shoulder which was diagnosed by his personal physician as bursitis. He was treated by local heat to the shoulder and shoulder exercises. The symptoms persisted for several months, but finally cleared.

In the fall of 1953 the shoulder pain recurred, and again he was treated with local heat to the shoulder. This was ineffective, and he was referred by his personal physician to a neurosurgeon for consultation. His history as subsequently obtained indicated that the neurosurgeon told him he might have a "cervical rib," but he obtained no x-rays and prescribed no treatment. Some six weeks after onset, the pain became sufficiently severe so as to disable him for work for two weeks. At the end of that time he voluntarily came to our Medical Department prior to a contemplated return to work.

X-rays of the cervical spine revealed degenerative changes with considerable narrowing be-

tween C6 and C7. Clinically at that time he had excellent range of shoulder motion and only slight limitation of cervical mobility on left lateral bending. Since his home was approximately 100 miles from Boston and since he was anxious to go home for the weekend, he was given a cervical traction apparatus and instructed to apply it continuously in bed for a 24 hour period, using from 6 to 8 pounds of traction. Three days later, after the weekend, he returned having obtained considerable relief and having been able to discontinue codeine that he had been taking. He then was given a Forrester collar to wear during the day and instructed to use the traction while sleeping. On this regimen he was able to discontinue all medication, even aspirin, within a five day period.

Although he remained comfortable, he consulted us again some two months later because his wife had noted some fibrillations of the muscles of the right upper arm. At that time we recommended cervical myelography primarily to rule out any possibility of a cord tumor. This was done, and while a cord tumor was ruled out, the myelograms definitely showed a disk herniation. He was not operated upon, but continued with the use of the collar and night traction for several months. For approximately the last four years he has used neither and has remained symptom-free.

The patient whose x-ray is shown in figure 2 is a 54 year old executive first seen in August 1953 because of pain in the right arm of three weeks' duration without a history of injury or other known precipitating cause and without a history of previous similar difficulty. Although he had no cervical symptoms, cervical motions were limited, and on questioning he complained of some paresthesias in the right hand and fingers.

His x-rays revealed much degenerative change, as shown in figure 2, with considerable narrowing of the space between C6 and C7, especially in the posterior portion.

He was given 15 pounds of cervical traction for 20 minutes on five successive days with complete relief at the end of that time. Three weeks later his symptoms recurred and again were relieved with four treatments. He then was symptom-free for two years. In 1956 his symptoms recurred briefly following a virus infection and again were promptly relieved by traction.

The x-ray in figure 3 was taken as a follow-up on the occasion of a visit to the Medical Department in October 1958 for an unrelated con-

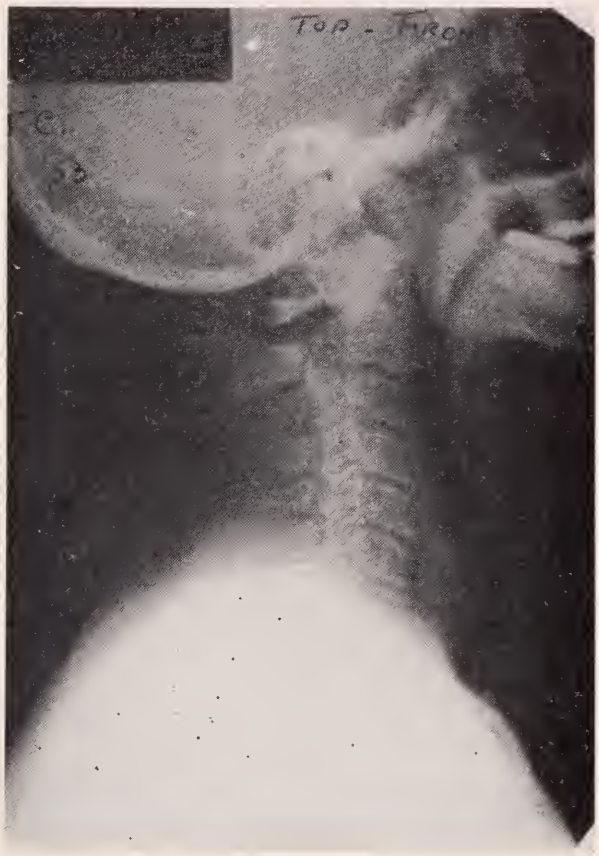

Figure 2.

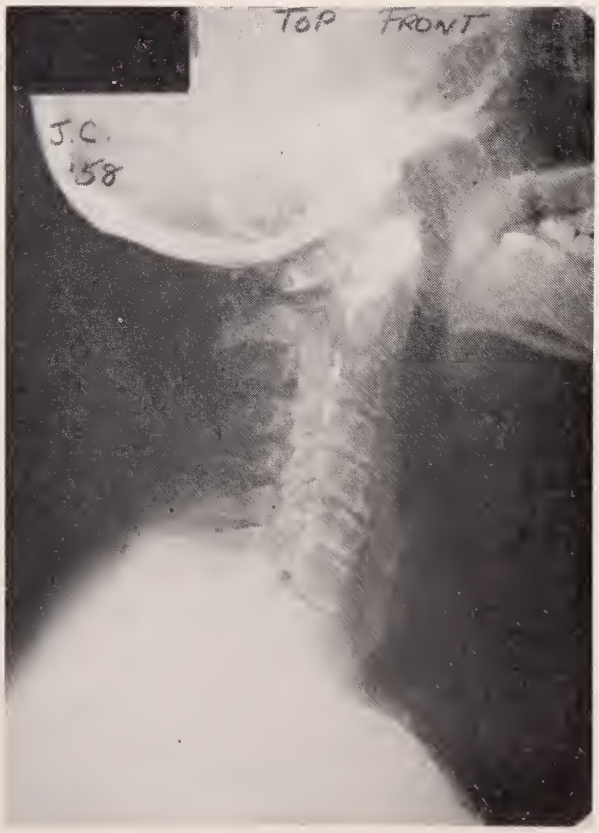

Figure 3.

Figure 4.

dition. The degenerative process has changed little in the five year interim, and he has continued symptom-free.

Although cervical radiculitis perhaps is not as frequent as the acute and chronic types of subdeltoid bursitis, failure to recognize it when it is present is unfortunate since it can be promptly relieved in most instances by the judicious use of cervical traction whereas treating it as a bursitis results in needless prolongation of discomfort and of disability. For several years now it has been our routine always to include x-ray of the cervical spine whenever ordering shoulder films or vice versa in any patient when the correct diagnosis is not immediately evident on the basis of objective clinical findings.

Congenital Anomalies of the Lower Spine

The "industrial back" is a hardy perennial in the field of industrial medicine. Volumes have been written on it. Among industrial injuries it continues to occupy a place high on the list of the costs of doing business, and it probably is safe to say that no other single condition provokes more head scratching, promotes more litigation, and consumes more time on the part of the industrial physician, the attorney, the insurance carrier, and the compensation commission, than does this one syndrome. Because psychic as well as organic factors can be involved and because organic pain can be present without demonstrable organic abnormality, the low back continues to vex us.

In that complete or permanent relief from any form of treatment is uncertain in so many cases, much industrial effort over the years has been devoted to ways and means of prevention. Safety programs, including instruction of workmen in proper methods of lifting and the provision of power lifts for the heavier types of work operations, have served to lessen the incidence of low back injuries to some extent. In recent times much attention also has been given to methods of selection and proper placement of the workman himself—to avoid putting a boy on a man's job, so to speak—for it seems reasonable to assume that the person with significant structural or functional impairments of the back will be more susceptible to injury from a given amount of stress upon his back than will someone without such impairments. It therefore follows that a program of careful pre-employment or preplacement medical examination will serve to detect many such potential accident hazards, and such a program does accomplish much.

A physical examination by itself, however, will not detect the many bony defects that may exist. Consequently, for the sake of a more complete examination and evaluation, many industries have embarked upon programs of x-ray of the lower back as a routine in the preplacement medical examination of applicants for jobs requiring reasonably heavy physical effort. Rather than contributing to a solution, this procedure in some respects seems to have compounded the problem. Particularly, I refer to the matter of congenital anomalies and their importance or unimportance. This has been and continues to be a moot subject. There are of course certain congenital defects, perhaps better termed abnormalities rather than anomalies, in the presence of which heavy physical work probably should not be undertaken.

Figure 4, for example, illustrates a case of spondylolisthesis. One would almost certainly conclude that this represents a distinct hazard for back injury. There is a large defect in the posterior elements of L4 with anterior displacement of L5 on the sacrum. There also is an exaggerated lumbar lordosis. At the time of examination, this young man was 17 years of age and

was applying for summer work in our cable forces, one of the heaviest types of work of all of our plant crafts. We did not think that he should be medically recommended for such an assignment.

Other similarly pronounced congenital abnormalities which we consider to be disqualifying for heavy work are listed in table 1.

Table 1.—Congenital Anomalies

Disqualifying conditions for heavy work

1. Transitional fifth lumbar vertebra
2. Unilateral articulation of transverse process with sacrum
3. Extensive spina bifida occulta
4. Spondylolisthesis
5. Prespondylolisthesis (defect of pars interarticularis

A greater problem of decision presents itself in the case of the less dramatic anomalies such as variations in articular facet structure, minor spina bifida occulta, extra lumbar vertebra, enlarged lumbar transverse processes, et cetera. In the case of the articular facets, some orthopedists believe that significant variations result in an unstable back, thus predisposing one to low back strain. Conversely, others believe that they are of no importance. Many radiologists do not even comment upon such anomalies when examining a film and usually report such film as normal unless they have been specifically requested in advance to look for and comment upon the facet structure. For a time we believed that facets were unimportant as long as they were symmetric at the same level, but that if they faced differently at the same level, this position would predispose to instability. We since have changed our opinion.

More often than not, congenital anomalies of the lower spine are apt to be multiple.

In the applicant whose x-ray is shown in figure 5, the facets between L4 and L5 face obliquely on the right and transversely on the left. Between L5 and the sacrum, they face transversely on the right and anteroposteriorly on the left. In addition, the left transverse process of L5 is large and articulates with the sacrum, whereas the right is of normal size.

In another young man, incomplete closure of the neural arches of L5 and of the first sacral segment is demonstrated roentgenographically in figure 6. In addition, there is a large winglike transverse process of L5 on the left which articulates with the sacrum and with some bone reaction evident.

Figure 5.

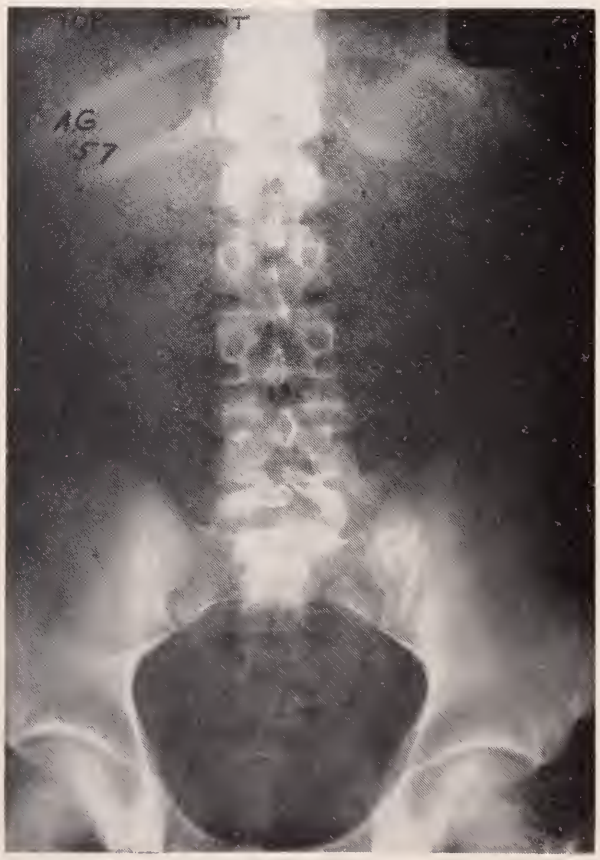

Figure 6.

Both of these examinations were made in 1953 when the Company was hiring substantial numbers of young men for plant craft assignments and when we had just instituted low back x-rays as a routine in preplacement examinations conducted at the Company's Boston Medical Office. At that time our medical recommendation was unfavorable for both applicants with regard to undertaking heavy work. Today, we probably would recommend the first medically, but would not modify our original opinion on the second, chiefly because of the bone reaction about the articulation of the enlarged transverse process.

As nearly as I have been able to determine, these lesser congenital anomalies of the lower spine do or do not constitute a predisposition to back injury depending upon whom one consults. In the absence of any conclusive studies one way or the other on the subject, such divergent opinions seem to be the result of individual personal experiences and convictions.

Special Study

Employees of the Bell System by no means are immune to back injuries. Some of the Operating Companies have programs of routine low back x-ray examination as a part of the pre-employment medical procedure; others do not. In 1955, a Medical Committee which I had the honor to chair, was appointed to study the back injury problem within the Bell System as a whole. To obtain a sufficiently large number of cases, the study covered the experience over a three year period. By means of a special questionnaire, certain basic data were obtained on each individual occurrence during this period in which either disability or job modification because of the injury (disability assignment) resulted.

Seventeen hundred and thirty-nine occurrences of such industrial back injuries of all types and at all spinal levels were collected. The total number of industrial injuries of all types for this same period was 6,517, so that back injuries represented 26.6 per cent of the total injuries sustained.

As one segment of this over-all study, it was hoped that an analysis of this group of cases would permit some definite conclusions to be drawn concerning the significance of congenital anomalies as a predisposition to low back strain. For example, an attempt was made to correlate the experience of those companies having a preplacement back x-ray program with those which did not. It soon became apparent, however, that correlation was impossible because of the presence of so many variables such as rate of hire, labor turnover, number of transfers from one job assignment to another, and number of employees in each company without back injuries, some of whom had had pre-employment back x-rays and some of whom had not. The Committee, therefore, as an alternative, studied the results from the aspect of severity rather than frequency since this was measurable and reasonably comparable.

For this purpose, all cases not preventable by any type of pre-employment examination were excluded, such as the fractures, contusions and abrasions, and multiple injuries. There was left a residue of 1,106 cases in which low back strain was diagnosed. This group then was separated into three divisions according to postinjury x-ray findings only, as follows:

1. Normal x-ray findings after injury.
2. X-ray findings after injury which might or might not have been present at the time of employment. This group consisted chiefly of cases of arthritis, other disease processes and narrowing of the fifth lumbar interspace and included 134 cases labelled as herniated disk suspects.
3. X-ray findings after injury revealing only congenital anomalies.

These three divisions or groupings then were compared on the basis of average days of disability and average costs per case.

Figure 7 compares the average number of days of disability per case. In the group with normal back x-rays the average was 21 days, while in the group with the congenital anomalies the average length of disability was 36 days. The average period of disability for the middle group was 67 days.

Figure 8 compares the costs. The cases of low back strain with normal back x-rays averaged $565 per case. The cases with x-rays revealing diseased processes and/or narrowing of the fifth interspace averaged $1,248 per case. The cases of low back strain, however, in which x-rays revealed only congenital anomalies resulted in an average cost of $1,440 per case, or more than two and one-half times that of the cases with normal back x-rays.

This Committee's study therefore developed nothing to indicate that the person with congenital anomalies of the lower spine is more susceptible to low back strain than is one with normal x-ray findings. It did, however, seem to show that if a person with such congenital anomalies sustains

a low back strain, the disability will be of longer duration and the costs greater.

Other approaches to the problem also have been made along the lines of what might best be described as a random sampling technic. This has consisted of obtaining low back x-rays on a series of persons with a history of chronic backache or reporting for treatment of symptoms of backache while at the same time obtaining similar x-rays on an equal number of persons with no back complaints and with no history of back injury or backache. Splithoff[1] reported in 1953 on such a study made at the New York Orthopedic Dispensary and Hospital. In addition to his own studies, he reviewed similar studies conducted by several other investigators. Splithoff's findings as well as those of the others tended to show that the x-rays of persons without backache revealed as many congenital anomalies of all types, including spondylolisthesis and transitional L5, as did those with a history of backache and in about the same percentage in each category.

Routine Preplacement Back X-ray Program Evaluated

Although these studies were interesting, they do not appear to shed any conclusive light upon the question as to whether such congenital anomalies do or do not predispose one to back strain. Because of lack of any definite evidence on this point one way or the other, the industrial physician frequently is hard put to decide whether he should inaugurate a routine preplacement back x-ray program for his industry, or, if he has one in effect, whether or not it should be continued or abandoned.

There does not seem to be any question but that a routine preplacement back x-ray program detects and serves to weed out a certain number of back abnormalities that would otherwise present rather definite hazards for back strain. A routine x-ray program of this type, however, also can be a fairly expensive undertaking. Of course, if the Plant Medical Department has its own x-ray facilities, costs usually can be maintained within reasonable limits. If the services of an outside private roentgenologist are used, both for taking the films and interpreting them, then each back x-ray will cost the industry anywhere from $15 to $20. If we assume a cost of $15 per case, then if 2,000 men were examined for employment in any one year, the cost of the back x-rays alone will be $30,000. Since the industrialist or plant manager is always concerned with costs, one way

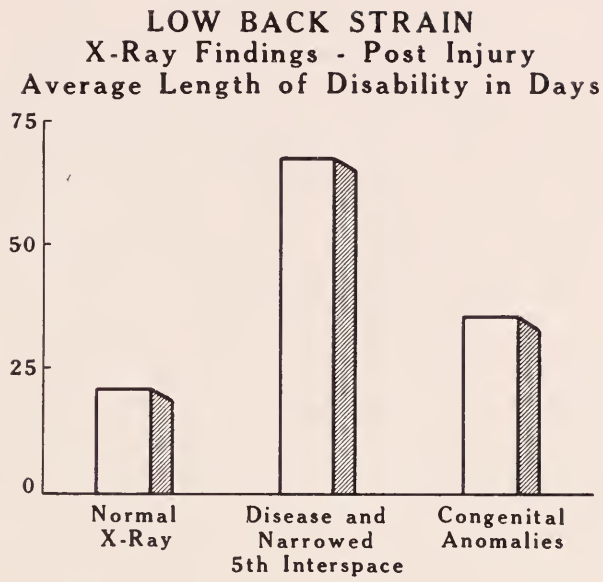

Figure 7.

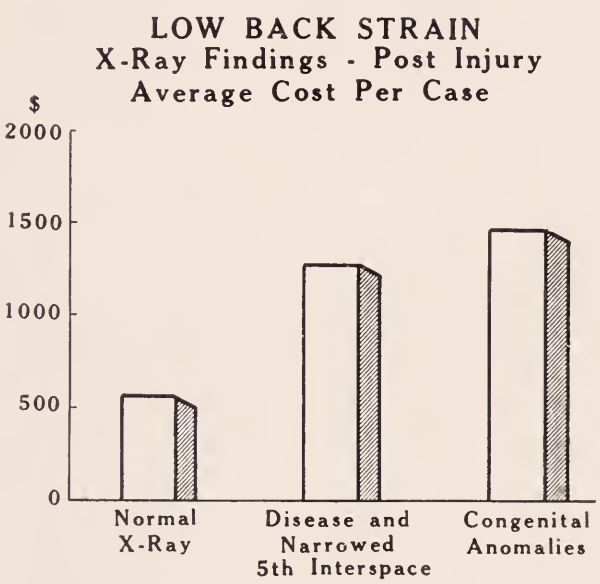

Figure 8.

to approach the problem is on this basis. For example, if a back x-ray program in a given industry will cost $30,000 a year and if the costs of industrial back injuries for a prior year averaged out to only $15,000, then the industry would probably lose $15,000 by installing such a program. On the other hand, if the program would cost $30,000 and the cost of back injuries that might have been prevented by this program cost $60,000 in a previous year, then it could be argued that the industry would save $30,000 by inaugurating such a program.

In initiating or continuing a routine preplacement back x-ray program, the subject of radiation exposure also is a consideration, especially in

view of the extensive publicity being given today to the hazards of ionizing radiation and its possible cumulative effects. Personally, I do not believe that the factor of radiation exposure from a routine back x-ray examination of an applicant should be an important consideration. In deciding whether to x-ray or not to x-ray, the best available studies[2,3] that I have been able to locate calculate an average gonadal dose of 100 milliroentgens from a routine x-ray of the lumbar spine in the male, which includes anteroposterior, lateral, and spot lateral views of the lumbosacral area and the anteroposterior view of the lumbosacral joint and sacroiliacs with the pelvis and hips receiving 450 milliroentgens. This is a relatively small dose, especially when one also considers the fact that it is received usually only once by any one person. Of course, the number of milliroentgens of exposure will vary up or down to some extent from the average dose just quoted, depending upon whether or not a low voltage or high voltage technic is used as well as target distances, amount of filtering, and other factors. The maximum permissible radiation dosage per week, however, to which a person presumably may be exposed with safety week in and week out is 300 milliroentgens.

As I have previously mentioned, we have had a program of routine preplacement back x-ray examinations in effect at the Company's Boston Medical Office since 1953. Such a program was inaugurated at that time so that we might convince ourselves eventually of its value or lack of value.

The New England Telephone and Telegraph Company operates in five New England states. Roughly half of our employees are concentrated in the Greater Metropolitan Boston area and are available to and usually are examined at the central Medical Office at Boston. The other 50 per cent of our employees are scattered throughout Maine, New Hampshire, Vermont, Rhode Island and the remainder of Massachusetts.

In 1953, because of continued expansion of the business, the Company was employing plant craftsmen in a reasonably regular and continuing fashion. Approximately half of the male applicants were examined at the Boston Medical Office and the other half were examined by the Company's local medical consultants situated throughout the entire New England territory. The male applicants at the Boston Medical Office had x-rays of their back taken as a routine. The male applicants examined by the Company's local consultants did not have x-rays of the back obtained in connection with their preplacement examination.

Covering the six year period 1953 through 1958 there was a total of 3,574 male Plant Department applicants x-rayed at Boston. During the same period there were 2,893 examined by our local medical consultants and employed without having had x-rays taken. Incidentally, of the 3,574 applicants, in 133, or 3.8 per cent, congenital anomalies were revealed which we believed significant enough so as to require special placement in employment. Initially, it was our intention to continue this program for a 10 year period and at the end of that time to analyze the industrial back injury experience of the x-rayed and therefore carefully selected and properly placed group and similarly to analyze the experience of the other 2,893 males who had not been x-rayed and therefore had not the same degree of careful selection in job placement insofar as the presence of any congenital anomalies in the lower spine were concerned. The second step then would be to assemble all the back injuries occurring in the non-x-rayed group and now, or at least at the end of the study period, to obtain x-rays on this group, which actually might be said to be serving as our control. In this way we hope possibly to come up with something that will give us more definite evidence on which to base a conclusion as to the value or lack of value of a routine preplacement back x-ray examination program.

Another interesting finding as the result of the study of Bell System industrial back injuries was that more than half of all of these injuries occurred within the first two years of employment. This has led us to believe that perhaps we do not need to wait a full 10 years before completing the study I have just mentioned. Since this is now the seventh year of the program, we are planning in the near future to begin such an analysis of the back injury experience of these two groups covering this six year period.

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Experiences With the Shirodkar Operation

A Preliminary Report

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Prematurity is the greatest single cause of death in the neonatal period, accounting for as many deaths as all other causes combined. As Eastman[1] stated, there are two ways of attacking the problem of fetal loss due to prematurity: first, by increasing the survival of premature infants born; and secondly, by lowering the incidence of premature delivery. The first of these is a challenge to the pediatrician, while the second lies in the province of the obstetrician.

Recently in obstetrics there has been a concentration of effort in the direction of the prevention of one of the demonstrable causes of premature labor, namely incompetency of the uterine cervix. In my study[2] of the effect of amputation of the cervix uteri upon subsequent parturition, reported in 1951, it was found that premature labor or abortion followed this operation in a large percentage of cases.

It is thought that the cervix acts as a ring to support the pregnant uterus and when this ring becomes incompetent the pregnancy will no longer continue, but rather will drop out. Patients with an incompetent cervix fall into a pattern as regards their obstetric history. Usually they have a history of a term delivery of rather precipitate nature, or of an operative procedure having been performed. Subsequent pregnancies continue to a point approximately four to six or seven months in duration and then spontaneously abort, almost without warning. The fetus in most of these cases is well preserved, showing that it was a developing organism up to the time when it was detached from its environment in the uterus.

Much attention has been directed recently to the early diagnosis of this condition and the treatment of it by purse-string ligation of the cervix in the so-called Shirodkar procedure.[3] This paper deals with a small series of cases in which this operation was performed in a general hospital as an independent study. It does not pretend to complement the much larger series present in the literature, but rather its purpose is to stimulate interest among the independent practitioners in the early diagnosis of this condition, and in the simple procedure for prevention of miscarriage in this small group of patients.

Case 1.—The first patient of the series was a 30 year old Para 1-0-1-1, first seen in the office on Nov. 4, 1957. She was referred by her family physician with the diagnosis that the cervix was dilated and the membranes presenting. Her last menstrual period had been on June 19, making her approximately 20 weeks pregnant. She related that in August 1954 she had delivered a seven pound baby rather precipitately after a labor of 90 minutes from start to finish. The patient had not been attended at the time of delivery, so precipitate had been the labor. In June of the following year she had spontaneously aborted a five month gestation.

She was seen by her family physician earlier in the morning of her office visit for the complaint of abdominal discomfort and bleeding. A speculum examination at his office had revealed the cervix to be dilated and the membranes bulging. This finding was confirmed upon my office examination, the cervix being dilated approximately 3 to 4 cm. with membranes at the level of the os. The patient was admitted to the Baptist Memorial Hospital immediately.

On admission, the hemoglobin estimation was 8.6 Gm. and the hematocrit reading 27. The patient received 500 cc. of blood on the day of admission and a second unit the following day. At this time a paper by McDonald[4] of Melbourne, Australia on "Suture of the Cervix for Inevitable Miscarriage" came to my attention. This author reported a series of 70 cases in which ligation of the cervix was performed for inevitable miscarriage, in most of which the period of gestation was between 20 and 24 weeks. Of the 70 patients in this series, 33 gave birth to infants that survived, whereas 16 others had their pregnancy extended by a period exceeding four weeks. He stated that when the method failed, it did so mostly during the first week following the operation.

Although this was a new procedure and not one receiving attention in the American literature at that time, it was decided to perform the operation upon this patient. With adequate consultation, since this procedure was other than the normal method of treatment in the community in which I practiced, the patient was taken to the operating room and a purse-string suture placed around the cervix. In the Australian study No. 4 Mersilk was employed. Since this was not available, a double strand of the largest suture material available, which was No. 3 silk, was used. Under general anesthesia this suture was placed at 2, 4, 6, 8 and 10 o'clock and the suture tied at 12 o'clock. By the time the patient was taken to the operating room, however, the cervix was almost completely dilated and the membranes were presenting at the introitus. It was necessary to fold these back into the uterine cavity and hold them there with a sponge stick until the purse-string suture was placed and drawn tight. Upon tying the suture, the cervix regained its normal appearance and length. The patient was given Proluton and Achromycin and was sent back to her room in good condition. Heavy sedation was also employed.

Approximately 24 hours later, the patient began to have severe pain, accompanied by firm uterine contractions. Speculum examination at this time revealed that the cervical suture had pulled out at its 6 and 8 o'clock insertions, being still attached at 2, 4 and 10 o'clock, and the cervix was dilated 3 cm. The patient was taken to

the labor room and at 6:50 p.m., approximately 25 hours postoperatively, she delivered spontaneously a four and one-half month premature infant, the heart action of which was good but the respirations immature. The subsequent course in the hospital was uneventful, and she was discharged on the third postpartum day.

Much was learned from this case despite its unsuccessful outcome, and confidence was gained for further work along this line. In retrospect, it was thought that had the procedure been performed upon admission when the dilatation was 3 to 4 cm., it might have been successful. Also, it was thought that the suture should have been of greater caliber and tied under less tension. It was determined to repeat the procedure should the situation present itself again, with these two changes in technic. Accordingly, office patients who gave the history of having repeated late abortions were looked for and examined at weekly intervals starting at the end of their first trimester. Fortunately, one of these was soon found, and hers is the third case presented herein. It is a typical example of the manner in which the Shirodkar procedure is indicated and can be of value in repeated abortions. Prior to this patient's appearance, the procedure was performed on a patient who threatened to abort without previous typical history.

About this time much attention was given in the American literature to the cervical closure of the incompetent cervix during pregnancy. An excellent study[5] from the George Washington University Hospital and the Walter Reed Army Medical Center stressed that aneurysm needles and broad suture material such as fascia lata from the thigh contributed to success. Other studies reported the use of a broad synthetic suture material called Mersilene, but the principle remained the same.

Case 2.—The second patient was a 28 year old Para 0-1-1-1. She was delivered by me of her first pregnancy, a 5 pound 2 ounce premature female child, on Sept. 3, 1955. She had spontaneous onset of labor at 36 weeks and a very rapid termination of her labor, going from 4 cm. dilation to delivery in 30 minutes. This infant survived without difficulty. Following this pregnancy, she aborted at approximately three months, spontaneously and without complication.

She was seen in the present pregnancy first on March 25, 1958 with a last menstrual period on February 12. The uterus was the size of a six week pregnancy. The pregnancy continued uneventfully until June when she was admitted to the Baptist Memorial Hospital with lower abdominal pain. It was thought at this time that she had an infection of the urinary tract and possible threatened abortion. She responded to bed rest, urinary chemotherapy, and sedation.

She was next admitted on August 21 for severe lower abdominal pain and uterine contractions. At this time she was approximately 27 weeks pregnant. At the time of each pain a definite firm uterine contraction could be felt. Morphine, grains 0.25, was employed for 48 hours with little relief of pain. Upon examination at this time it was found that the cervix had begun to dilate and was approximately 3 to 4 cm. dilated.

Despite this patient not falling into the group with incompetency of the cervical os, her history did match that of patients in the Australian group on whom suture of the cervix was performed for inevitable abortion. On August 23, approximately 48 hours after admission, the patient was taken to the operating room and a Shirodkar procedure performed. Since the Mersilene suture most recently recommended was not available locally, a 16 gauge polyethylene catheter was employed as suture material. A small incision was made at 6 o'clock in the region of the attachment of the mucosa to the junction of the fornix and with an aneurysm needle the suture brought forward to 12 o'clock where it was brought through the mucosa. This step was repeated on the other side and the polyethylene catheter tied down, its purse-string arrangement closing the cervix. The following day there was a noticeable decrease in the number of contractions and in discomfort, and the patient was discharged on the fourth postoperative day.

She was readmitted on September 23 with severe abdominal pain, and again uterine contractions were present. Examination at this time revealed the cervix to be as tightly closed as at the conclusion of the operative procedure of the preceding month. The contractions were finally controlled with bed rest and sedation, and the patient was discharged with tincture of opium prescribed and bed rest at home except for meals and bathroom privileges. Prior to this admission she had been allowed full time activity at home.

Her fourth admission was on October 15, approximately five weeks prior to her estimated date of confinement. At this time she was having firm uterine contractions. Speculum examination revealed the cervix to be tightly closed. It was elected at this time to remove the purse-string suture on the judgment that the patient would spontaneously deliver from below a fetus capable of extrauterine existence, such being preferable to cesarean delivery with the suture intact. It was thought that the patient could carry the pregnancy little longer, and there was some fear that the suture might tear through the cervix and amputate this organ. Accordingly, the suture was removed, and the patient was delivered of a 4 pound 9½ ounce premature living normal male child, who is getting along well.

This case points out the employment of this procedure in cases of inevitable abortion. Here it was successful in prolonging a pregnancy from a time when the infant definitely would have been immature to a time when the infant survived. This patient was able to carry her baby an additional eight weeks by the simple procedure of purse stringing the cervix, and then was allowed to deliver vaginally.

The third case to be described is that of the patient with a typical history of incompetency of the cervical os, who was followed closely in the office and diagnosis made upon dilatation of the external os. This patient was treated in the fashion advocated by several of the studies in which the closure of the cervix was carried out during pregnancy, the suture left in place, and the patient delivered by cesarean section.

Case 3.—A Negro woman was first seen in the office on Sept. 19, 1957 for initiation of maternity care for her fourth pregnancy. Her previous three pregnancies had

ended in spontaneous abortion, the third of which was in 1954, at five months' duration. Her past history was entirely normal, showing no operations, serious illnesses, transfusions, or unusual deviations from general health.

Examination at the time of her initial office visit showed a moderately obese woman approximately four and one-half months pregnant by abdominal palpation. The cervix upon vaginal examination was found to be shortened and the external os patulous. A diagnosis of pregnancy in an habitual aborter was made, and the patient was given an equivocal prognosis. Dienestrol was prescribed, and when she was seen in the office a month later, the pregnancy was progressing normally, fetal movement being discerned.

She was next seen in Brewster Hospital three weeks later on November 4 with the history that the membranes had ruptured two days before and that cramps had commenced the morning of admission. At this time she spontanously aborted a five month pregnancy.

She was seen for her fifth pregnancy on June 30, 1958 with a history of her last menstrual period on February 10. She had already felt the baby move. Examination revealed the height of the fundus to be 23 cm. and the fetal heart tones not heard. The cervix was somewhat shortened but closed. At this time she was advised to be checked in the office for cervical inspection visits at weekly intervals in addition to her regular maternity visits. She was subsequently seen at weekly visits in the office until September 10. On the visit of August 27 the cervix was finger-tip dilated and also on the intervening visit of September 3. On September 10 the patient began to spot and have abdominal cramps. She was admitted to Brewster Hospital and on the next morning examination revealed the cervix to be 3 to 4 cm. dilated and two thirds effaced. The abdominal cramping continued.

An x-ray examination was performed, showing a fetus of approximately four pound size occupying a breech position. The patient a few hours later was taken to the operating room where a Shirodkar operation was performed employing the 16 gauge polyethylene catheter. She was discharged four days later and next seen in the office on October 1. At this time the cervix was nicely closed and the patient was scheduled for cesarean section on October 20, which was approximately four weeks prior to her estimated date of confinement.

On October 15 the membranes ruptured spontaneously at home at 4 a.m., and she was taken to the hospital where a laparotrachelotomy was performed at 6 a.m. with delivery of a 7 pound 2 ounce full term living normal male child. The baby and mother were discharged on the fifth postoperative day.

Comment

A summary of my experience with the Shirodkar procedure shows that it is necessary to employ broad suture material and to perform the procedure prior to full dilatation of the cervix. The polyethylene catheter employed in this series in the second and third cases was satisfactory and had the advantage of availability and flexibility. Additional cases will be treated with the same material in order to evaluate it and to compare results with those obtained with the commercially available Mersilene.

In my opinion the Shirodkar procedure should be a part of the armamentarium of any physician practicing obstetrics and can be used either in cases of inevitable abortion, as in case 2, or in cases of incompetency of the cervical os, as in case 3. As the latter case illustrates, it is not difficult to examine the habitual late aborter at weekly intervals with a vaginal speculum in order to pick up the dilatation in time. This plan has been recommended by many of the authors on this subject. In addition, in the patient seen for the first time with beginning dilatation of the cervix and uterine contractions, and with a viable fetus with good heart tones and minimum bleeding, certainly it is a procedure to be tried. Without it, the incidence of abortion and neonatal death is 100 per cent; with it, there is at least a chance of continuance of the pregnancy for a sufficient number of weeks until viability and survival are reached.

As the procedure becomes more widely described and employed, the incidence of success will increase. It is necessary, however, to stress the importance of not overdiagnosing the necessity for this procedure. It should be used only in those cases in which abortion would otherwise occur, or in cases with a strong history of late abortions, because its employment usually dictates not the one operation of the Shirodkar procedure but a second operation of cesarean delivery. A cesarean section is not always necessary, as has been demonstrated, since the suture can be removed. If subsequent pregnancies are desired by the patient, it is better to leave the suture in place and perform abdominal delivery.

Summary

A procedure has recently been introduced into the field of obstetrics whereby some spontaneous late abortions may be prevented and the pregnancy carried to term or near term.

This procedure consists of purse stringing the uterine cervix at approximately the level of the internal os.

This paper discusses the indications for the employment of such a procedure, presents one method of treatment thereof, and discusses the results in a small series of cases.

The main purpose of the paper, however, is to bring out certain practical points in the use of this new procedure by relating the clinical aspects of the cases reported, and thereby to encourage the physician specializing in obstetrics to include this procedure in his armamentarium.

Addendum: Since the submission of this paper for publication, a fourth case has been managed by employment of the Shirodkar procedure. The patient had previously delivered a 32 week fetus which did not survive. In the present pregnancy the cervix was in-

spected at weekly intervals. On Feb. 17, 1959, inspection revealed a beginning dilatation of the cervix. The Shirodkar procedure was carried out later that day, at which time the cervix was completely effaced and approximately 4 cm. dilated with the membranes and fetal head visible. Heavy progesterone supportive therapy was employed owing to the presence of some uterine contractions. The patient was delivered six weeks later of a 5 pound 3 ounce premature female living child under saddle block anesthesia and over a generous left mediolateral episiotomy following a long labor. The Shirodkar suture was removed prior to labor in preference to performing cesarean section because of the premature size of the baby. Examination at six weeks postpartum revealed the cervix to be closed but definitely shortened. It is planned to perform cervical repair prior to the onset of another pregnancy.

Also since this paper was submitted for publication, an excellent paper presenting a large series of cases has been published (Easterday, C. L., and Reid, D. E.: Incompetent Cervix in Repetitive Abortion and Premature Labor, New England J. Med. 260:687-690 (April) 1959).

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Listeriosis

A Growing Public Health Problem

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Listeriosis is a relatively unknown widespread bacterial disease of man and other warm-blooded animals. The etiologic agent, Listeria monocytogenes, has been recovered from man, mammals and birds in nearly 30 countries and in diversified geographic areas ranging from the Arctic to the Tropics. Natural infection of animals has been observed with increasing frequency, and L. monocytogenes has been isolated from over 28 animal species such as guinea pigs, chinchillas, ferrets, chickens, geese, hamsters, rabbits, mice, rats, voles and gerbilles. The disease is common in cattle, and sheep are especially susceptible. The majority of infections have been proved to occur in domestic animals, but it is significant that there exists an abundant reservoir among wild species, many of which are migratory and some of which are predatory.

The increasing number of human cases and the fact that it is being associated more frequently with disease of livestock and poultry make listeriosis a much more important disease than it was considered to be previously.

History

Listeria monocytogenes was first isolated and studied in 1924 by Murray, Webb, and Swan from an epizootic affecting their laboratory rabbits.

The organism called Bacterium hepatis in 1911 by Hulphers was undoubtedly L. monocytogenes. The same organism was recovered by Pirie from wild gerbilles in South Africa in 1925. He named it Listerella hepatolytica, since it attacked the liver of the infected animal. English workers finally renamed the organism Listerella monocytogenes. The generic name Listerella was changed by the Third International Congress of Microbiology in 1939 on the grounds that Jahn had already used the name for a mycetozoon in 1906. Pirie, in 1940, suggested calling the organism Listeria, and this generic name is now generally accepted.

In 1929 Nyfeldt recovered the organism from the bloodstream of a boy with infectious mononucleosis, this being the first recognized isolation of Listeria from a human being. Gill was the first to recognize the disease in domestic animals. In 1931 he isolated it from sheep in New Zealand and gave the name "circling disease" to the encephalitis which it caused. Since these initial publications, there has been an increasing number of reports concerning Listeria in the medical literature throughout the world.

Bacteriology

Morphologically, L. monocytogenes is a gram-positive, non-acid-fast non-spore-forming rod. There is a tendency for the organisms to form palisades or to arrange themselves into V's when

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the smear is made from solid mediums. This arrangement of the bacilli is similar to that seen in the case of diphtheroid bacilli. The bacteria stain evenly and are 0.5 to 0.6 by 1.0 to 2.0 microns in size. Growth is usually sparse on plain agar medium, but is usually luxuriant on mediums enriched with glucose or body fluids. On blood agar distinct beta hemolysis is usually evident within 24 to 48 hours of incubation.

Listeria organisms differ from nonmotile diphtheroids in that they are sluggishly motile. They exhibit a characteristic spiral or "tumbling" movement. Motility is usually apparent within 24 hours and is best observed on semisolid mediums.

Listeria monocytogenes produces acid but no gas in a variety of carbohydrates. At least four antigenic types are known.

It must be remembered that Listeria may be confused with nontoxigenic Corynebacteria and occasionally Streptococci.

Diagnosis

The actual diagnosis of listeriosis depends upon the awareness of the bacteriologist, in view of the fact that the clinical features of this disease are not well defined. Cultures should be made from cerebrospinal fluid, blood, urine, meconium, pus and exudates according to the particular case. At autopsy, cultures should be made from all organs. Brain tissue, especially the medulla oblongata, should not be forgotten. Microscopy is of utmost import, and hanging drops for characteristic "tumbling" should always be performed.

Another test of great value in confirming the presence of Listeria is the so-called "conjunctival test." Two drops of an overnight broth culture of Listeria are instilled into the conjunctival sac of a rabbit or guinea pig. An intense purulent keratoconjunctivitis will usually occur after 48 hours. The specificity of agglutinating titers is questioned since Listeria has common antigens with staphylococci and with Streptococcus faecalis. Also, because of the fact that the agglutination titer diminishes rapidly, it is not reliable for late diagnosis.

Clinical Findings

Six types of listeriosis have been described by Seeliger. The relative frequency of the types encountered is as follows:

1. Septic type with mononucleosis 8 per cent
2. Oculoglandular form 6 per cent
3. Septic typhoid form 21 per cent
4. Infection of the central nervous system 33 per cent
5. Granulomatous sepsis of the newborn 29 per cent
6. Listeriosis in pregnancy

The clinical picture caused by L. monocytogenes in humans has been described as a meningoencephalitis. In children and adults the following observations have been made: sudden or gradual illness with fever, vomiting, headache, lethargy, stupor, irrationality, convulsions, strabismus, ptosis, diplopia and rigidity of the neck. Listeria meningitis in man resembles other purulent meningitides and it cannot be distinguished clinically from meningitis due to other bacteria.

A form of human listeriosis known as granulomatosis infantiseptica is second only in importance to listerial meningitis. This is an intrauterine infection with a high mortality rate for the fetus or the newborn child. Curiously, it does not seriously affect the mother, who may be entirely asymptomatic, although more commonly there has been a history of influenza-like symptoms characterized by slight chills, lumbar pains and slight elevation of temperature a week to a month ante partum.

Septicemia is probably the most commonly occurring form of listeriosis in man. The involvement of the reticuloendothelial system stimulates a monocytic response, thus causing confusion in differentiating the disease from infectious mononucleosis.

It is obvious that the clinical manifestations of listeriosis are diverse, since they include abortion in cattle, sheep and goats, mononucleosis in man, and meningeal or encephalitic infection in man, cattle, sheep, goats and swine. Involvement of the central nervous system, considered the most characteristic form of the disease in ruminants, is manifested by abnormal posturing of the animal's head and neck and its walking aimlessly in a circle ("circling").

Epidemiology

Listeriosis is a disease with an extremely widespread distribution, involving many unrelated and varied hosts with widely different food and living requirements. The source of Listeria infection in human cases is rarely discovered. There is no evidence that the disease is transmitted directly from animals, and it is generally agreed that in babies the most likely source of infection is the maternal genitourinary tract.

The clinical, pathologic and bacteriologic characteristics of listeriosis vary in different hosts, and there is no indication whatever that this variation is due to differences in species, variety or type of infecting bacterium. The species character of the microorganisms isolated from all kinds of hosts in every country seems clearly to be homogeneous and identical in essential ways, with the exception only that there may be different serotypes involved in different regions and that individual strains may show greater or lesser degrees of virulence to laboratory animals.

Transmission from human to human (except transplacental) has never been proved. Some have postulated the gastrointestinal tract as the most likely route of entry. The isolation of L. monocytogenes from the cervix of lactating cows may explain why raw milk may be a source of infection.

The epizoology and epidemiology of listeriosis is still not clear. It is known that listeriosis occurs in wild mammals including birds and rodents. It is possible that transmission from group to group exists, but the mechanism has never been determined. Direct contact may possibly play some part in the spread of this disease among animals. Ödegaard, Grelland and Henriksen reported a case which presumably was transmitted from sheep.

In animal infections there is a definite seasonal distribution. The greatest number of cases occur in the spring and winter months. This does not appear to be true of human infections. Sex and age distribution in both man and animals show little differences in the incidence of infection, but the younger the creature, the more unfavorable the prognosis.

Since 1950, 83 human cases and over 2,000 animal cases have been confirmed in the United States. It can, therefore, be concluded that listeriosis is a growing public health problem, especially since little is known regarding the frequency and even less concerning the epidemiology of this disease. The most important factor in the recognition of this relatively new disease entity may well be an awareness of its existence.

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FLORIDA MEDICAL ASSOCIATION ANNUAL GOLF TOURNAMENT

The Golf Tournament will be held at the Selva Marina Country Club, Atlantic Beach, and will be terminated Saturday, April 9. All local physicians are requested to play during the week prior to Saturday (April 9). Competition again will be made for the Duval County Medical Society Trophy as well as the Orlando Loving Cup.

Prizes will be awarded Saturday night, April 9, at the Woman's Auxiliary buffet dinner and dance at the Mayflower Hotel.

Participating physicians may purchase chit books at the club. For additional information contact Dr. A. Judson Graves, Chairman, 1661 Riverside Ave. or Dr. George M. Stubbs, Co-Chairman, 2033 Riverside Ave., both in Jacksonville.

Problems of the Blues

Samuel M. Day, M.D.
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As Blue Cross and Blue Shield coverage has become more widespread, it is only natural that the problems encountered in administration have increased many fold. Since these are comparatively new organizations in the insurance field, there may have been costly delays in making proper adjustments for these problems with resulting serious lapses in public relations. In some instances this may have seemed to make a paradox of a very definite Blue asset. The professional guidance given voluntarily by well qualified doctors and hospital administrators to the Blue Plans would be a very costly item, if obtainable, by ordinary insurance companies. This gives us an unselfish personal touch unmatched in insurance. It gives special consideration to the problems of the patient and the doctor by people who encounter those same problems day by day. Unfortunately, this excellent advice must come slowly because the primary occupation of these men lies in their profession rather than in insurance. Deliberations may be so long drawn out that interested parties have become embittered and have turned against the only insurance that embodies their own interest.

The Blues of Florida present no exception to these very serious difficulties. Many conscientious doctors are "at their throat" because of misunderstandings caused by delays and by actions, reports and policies untempered by the soothing touch of those more expert in public relations. We hear it said that "doctors are not insurance-minded and should get out of the field." Such an exit would be a grave mistake because doctors are medical-minded, and who but them can solve these medical problems? They may not solve them as quickly or as glibly, or as positively, as insurance men, but assuredly they will do it with feeling and conscientious thought for those involved.

These doctors and their lay experts have been able to do their job so well that these Blues have thus far been the major factor in delaying and, possibly, defeating the socialization of medicine. They have shown the professional insurance men how to do what these same insurance men said could not be done. Furthermore, the success of the Blue Plans has made their idea a major attraction to the profit-minded insurance companies. Certainly we have no quarrel over one's right to make money in his own way. That is a fundamental principle of our country which makes it great. We are not, however, so naive as to fail to see that money can be the basis of selfishness, and "big money" may breed "big selfishness." The doctors' interests can get lost quickly in the rush of "big insurance." Competitively, there are tricks of the trade that we are slow in grasping; the very personal nature of our organization leaves us open to these maneuvers. As in a dictatorship, "big insurance" can make quick decisions and take quick action, sometimes leaving the Blues seemingly far behind. But never fear, unless we are destroyed from within by quibbling and backbiting by those who honestly misunderstand the organization and those who for selfish reasons would prefer to better other ends than those of their profession, the Blues will not only survive but will continue to lead the way—and with a medical viewpoint.

That doctors are human cannot be questioned. Patients are, too. This qualifies each to make honest errors as well as dishonest forgeries. Fortunately, those who are inclined to the latter are in the extreme minority, but they do present themselves from time to time. Checks and balances are a necessary part of our organization; the Claims Committee has this as its major reason for being. This committee in our state is composed of an anonymous group of volunteer doctors from various fields of practice who meet semimonthly to consider major problems and recommend solutions. They are advised by a lay claims expert and one part time physician who has been a member of the Claims Committee for 12 years, but recently has been paid for approxi-

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Dr. Day has served on the Claims Committee for 12 years; during the past three years he has also been part time medical consultant helping with the more involved problems. Desiring to devote more time to his family, his practice and his educational activities, he has resigned after securing a capable replacement. In hopes of promoting better understanding between the doctor and Blue Cross-Blue Shield, he publishes these reflections as some of the major problems encountered during his period of service.

mately 12 hours monthly to contribute much more in time and knowledge. These interested persons may not always come up with the right answer, but it is beyond question that they have given sincere consideration to the problem at hand with the unselfish interest engendered by mutual understanding. These "Problems of the Blues" are their problems. They are our most expert word, but in keeping with the democracy of the Blues, they are not necessarily the final word, as one can always appeal to the Board of Directors if not satisfied with Claims Committee decisions. The Board is elected by the House of Delegates of the Florida Medical Association. Its members also serve without pay and are charged with matters of policy as their primary duty. A capable lay Executive Director and a staff of 325 carry out their policies.

Major Problems

Problems of the Blues have been found to fall into 10 categories: (1) Pre-existing Conditions, (2) Diagnostic Admissions, (3) Concurrent Care by More Than One Doctor, (4) Discrepancies in Diagnosis and Treatment, (5) Failure to Appreciate Service Benefits, (6) In-hospital Complications, (7) Office Surgery, (8) X-ray Therapy, (9) Cosmetic Surgery, and (10) Other Healing Arts.

Just as a casualty company cannot insure a house that is already afire, health and hospitalization insurance cannot underwrite a disease that is already under way. Even clearcut cases are sometimes difficult to decide, but incipient diseases, like smouldering fires, may be extremely hard to judge. Riders may be attached to individual contracts in order to permit patients to obtain Blue Cross and Blue Shield, yet protect the Plan from conditions known to exist before the contract. Riders are worded for the benefit of the Plan since they are issued for the benefit of the patient. They must be unusually broad because of the odd claims and interpretations made by some patients, some doctors, and even some courts.

Reliability

Of all the Blue problems, that dealing with questionable reliability of the patient's and the doctor's word makes administration more difficult. Sometimes responsibility for payment of rather large sums of money may rest on a few words given by the patient to his physician and by him in turn to an insurance company. Medicine is usually regarded as an honorable profession and very likely the veracity level is higher in medicine than in most other walks of life, but when seeing it from an insurance angle, an idealist would certainly become depressed at what he saw. Much of the difficulty may stem from the doctors turning matters over to secretaries and others, and not taking the time to inform them correctly of the facts. Too frequently, however, it seems to be a weakness on the part of the physician to yield to pressure by the patient, quite possibly due to sympathy, but sometimes with the background holding the reward of a paid bill.

Initially, claims personnel of the Blues took the doctors' statements without question, but after encountering changing pictures, conflicting stories and impossible situations, the Claims Committee has been forced to rely more and more on hospital records and other information available to it. It makes an interesting but discouraging picture to compare various stories on a single case.

To illustrate only a few, some of which are comical and some are not, some explainable and some not, the following examples are presented:

Dr. X furnished medical information for a Blue Cross–Blue Shield family application indicating that a husband and wife were in perfect condition. Shortly thereafter a note from the doctor was received which stated: "Had a great deal of pressure put on me today and would have withstood same, but the parties concerned had managed to reach my wife. You will receive applications mailed tonight from Mr. and Mrs. S. They were 'all filled out for me,' and my wife was very anxious as she said any delay would mean dire consequences for me. So I took the easy road. To begin with, they are neighbors and not patients of mine. Also I understand that Mr. S is a heart case under the care of Dr. W and that Mrs. S has angina and both of these could be wrong, but would suggest you not accept either one of them until you have made further inquiries, and I should be more than delighted to hear what you find for the heat was really on me today and unfortunately from my own family; so I thought the easiest way out would be to fill in the forms as they had suggested and then just drop you a line for I certainly will be no party to any dishonesty in insurance forms."

By means of the letter the good doctor removed himself as a party to dishonesty, but would not the patient and all of us have re-

spected him more if he had retained a basic honesty and had the will to defend it, rather than explaining his weakness behind the patient's (and his wife's) back and giving the Blues the difficult public relations job of rejecting a patient without justifiable cause so far as the patient can see?

The next case also turned out right in the end, but after much more correspondence as well as some rather odd feminine reasoning with complete justification of self. The patient was admitted to the hospital four months after the effective date of the coverage. The diagnosis was chronic perianal dermatitis. Additional information was requested from the lady doctor who stated that the condition had existed for approximately a year. Further information indicated the condition had been present for "several months;" so benefits were denied on the basis that the condition existed prior to the effective date of the contract.

Shortly thereafter, an angry letter from the irate subscriber enclosed a letter she had received from the doctor, which is quoted: "In reply to your request with regard to the trouble you were having with your rectum, may I say that having examined you on numerous occasions, my examination on July 15 was the first time I ever saw the difficulty which finally led to your being operated upon." (The July 15th examination that the doctor had made was approximately one month after the effective date of the coverage.) "At my previous examination two months before, there was no such condition present, and that is the reason nothing was suggested in the way of treatment. I felt at the time and still feel that the condition which led to surgery was an acute one, and because of that belief I cannot see any reason to feel that it existed for any appreciable length of time before you were operated. As I stated before, I know from my own examination that it was not present late in May. I trust that this will answer your questions with regard to the duration of your illness. Since I have been taking care of you for two years, I feel qualified to make a definite statement on the subject."

Photostatic copies of the doctor's conflicting letter and questionnaire were then sent to the doctor with a request that she put us straight. Soon this letter was received in reply, "Let me say that I fully remember my previous report and understand your attitude completely. I felt sure that in view of that previous report anything that I may have written to the patient would cause you to make the proper decision. It is sometimes extremely difficult when the letter is to go through the hands of the patient to be completely frank. I hope that you understand my position and will realize that in view of my previous report I felt that there would be no miscarriage of justice. I trust that this will clarify the situation." It DID, but as an interesting postscript the hospital record signed by that same doctor stated, " . . . chief complaint of rectal itch of *14 years* duration."

These are extreme cases with a humorous twist. Correspondence was the most difficult administrative problem involved, but even that is time-consuming. Since some Florida Blue contracts specifically exclude "services during the first nine (9) months after the effective date of this contract for any conditions existing or originating prior to the effective date of this contract, and service for any condition for which medical or surgical treatment or advice has been rendered within one year prior to the effective date of this contract," a great burden of interpretation rests upon the Claims Committee. Recognizing that many of the claims possibly represent the patient's only current means of meeting serious financial obligations, the Claims Committee seriously weighs each available fact before making a decision. Since people do falsify information and sometimes even change doctors so that the true facts will not come to light, the Claims Committee must remain objective in its thinking. Consequently, pre-existing conditions are decided on the basis of the time of onset of symptoms related to the condition and/or the reasonable period of time expected in the development of a condition based on history, physical findings and pathology. To our regret, that sometimes forces us to go completely against the sincere advice of the patient's physician. It must be noted that the contract does not in any way state or imply that the patient or the doctor must KNOW of the existence of the condition. These are group contracts and, of necessity, they are accepted without history. Individual contract holders are theoretically never covered for pre-existing conditions.

One of the really difficult problems is herein illustrated. The group contract was effective on Aug. 1, 1956. The patient was first hospitalized on Sept. 26, 1956, approximately four months later. The history revealed the patient to have had radical mastectomy in another state in No-

vember 1954 for adenocarcinoma of the left breast, without axillary metastases. In August 1955, the same doctor performed a biopsy and partial right mastectomy because of a tumor said to be benign. A hard area was noticed at a stab wound drainage site beneath the breast a few weeks after the operation. In the meantime the patient moved to Florida and took Florida Blue Cross and Blue Shield. She was seen a short time later by a Participating Physician who advised biopsy of the firm area. This proved the presence of adenocarcinoma, and radical mastectomy was performed. We were not able to accept liability for Blue Cross and Blue Shield, although we were most sympathetic for an unfortunate victim of circumstance. She knew she had the lump, but she did not know it was malignant. We feel that malignancy with that history did not likely develop in four months. The problem was to continue to haunt us as the patient was readmitted to the hospital before the nine month waiting period was completed. This time she had bilateral oophorectomy, and incidental appendectomy, as further treatment for the carcinoma of the breast. Probably there was no legal liability, but the Claims Committee decided to pay this admission without precedent. Did we err? Although our organization is nonprofit, it is not charity. Already we return 90 per cent of the rate income to the subscriber, not leaving us too safe a margin for required reserves. The Boards of Directors can be held legally responsible for Blue Cross and Blue Shield monies; so we must be doubly careful in rendering decisions.

Diagnostic Admissions

Diagnostic admissions represent the other most difficult problem to interpret. Here also, failure to pay attention to details or downright dishonesty on the part of the patient and the doctor are the complicating factors. Too often we doctors permit the patient to make the decision as to "when to hospitalize." Typical of this thinking is the patient who was hospitalized for gallbladder x-rays and no treatment for a condition of long duration. On rejection of the claim by Blue Cross, her doctor wrote, "Miss _____ states that had she known this would be considered diagnostic only, she would have obtained her x-rays as an outpatient," which is just what the Blues have been begging patients to do for a long time.

A different approach is illustrated by this doctor of integrity. After his patient with gastritis was hospitalized for gastrointestinal x-rays, the doctor sent her the following letter, "I am taking this opportunity to confirm my verbal resignation, as of Tuesday, March 20, from your case. Your symptom complex is one that, had you had the patience to wait for a physician's impression, you could adequately have been treated on an outpatient basis. Be that as it may, your attitude in this instance precluded the doctor-patient relationship so necessary to therapy."

It is not proposed that we go to either of these extremes in dealing with these patients, but we should inform our patients of two basic facts:

(1) The patient's part of the hospital bill for diagnostic admissions is usually as much or more than the cost of the studies as an outpatient.

(2) The case may be rejected by Blue Cross–Blue Shield, so that the cost may be much greater than for the desired studies on an outpatient basis.

Here again, the Claims Committee attempts to weigh carefully all available facts. We have a somewhat paradoxical situation in that certain diagnostic studies, namely, diagnostic endoscopies, are listed items in our fee schedule. One can easily see how this makes a doctor "see red" who wished to make studies which are just as important and possibly even more indicated, but simply are excluded from the present Blue Cross–Blue Shield Contracts.

Be it right or wrong, the Blues were established initially to cover items that were considered predictable, were easily verifiable, and were somewhat limited in desirability by associated patient suffering as well as by anatomical maximums as to organs available. Those familiar with the history of the Blues will recall that one or two pioneers began with the coverage of medical and surgical procedures. They were quickly in financial difficulties and were forced to eliminate the more costly items, which happened to be medical and diagnostic ones. Was it not natural for other less original plans to profit by their mistakes? It was only when the medical doctors recognized the importance of Blue Shield to their own economics and began to take an active interest in its affairs that this picture began to change. It is hoped that our able liaison committee and the Blue Cross and Blue Shield Boards will work out a satisfactory solution in the near future.

The Blue Cross and Blue Shield Contracts state, " . . . specifically excluded: Any service to a subscriber primarily for rest or rest cure, primarily for diagnostic purposes or any service obtained or obtainable without cost to the subscriber from any governmental agency." The Claims Committee, in attempting to be as liberal as possible, has tried to pay for acute cases that required hospitalization for the safety of the patient even though they may have been primarily diagnostic. Even this is very difficult to determine sometimes with the cooperation we do not get from some doctors. A case in point is a recent one in which the doctor's Service Report and questionnaire stated the patient was acutely ill with hematemesis. Naturally we thought this a justifiable reason for admission, but a look at the hospital billing suggested that we get more information. The hospital records made no mention of hematemesis, but did list melena. That same doctor had written a progress note in which he stated that the patient was a heavy drinker, her story unreliable, and he doubted that there had been any bleeding. It was rejected as "an admission primarily for diagnostic purposes." A short time later a "certification" was received from the doctor in which he *certified* that the hospitalization was for the treatment of bronchial asthma. Absolutely no mention of asthma or any bronchial disease and no treatment for same in the hospital records or in any previous correspondence was found. This was called to the attention of the doctor, and we have heard no more. Probably simple carelessness, but it takes time to review the case repeatedly and adjudicate it fairly.

A significant illustration is that of the Blue Shield Board member who admitted a patient especially for treatment and diagnostic studies and did not find it necessary to treat in the hospital. The Claims Committee cannot base its decisions on its knowledge of the intent at the time of admission, or of the integrity of the individual doctor or patient. Too many patients and doctors unknown to the committee would suffer by such standards. It may be well to say that all claims should be paid and they would repay the Blues in public relations. The Blue Cross and Blue Shield Boards requested a study to determine what the cost of such a procedure might be. The results of the study were revealing. Diagnostic rejections had increased from 0.2 per cent of the total cases processed in 1955 to 1.22 per cent in 1958. Pre-existing rejections retained approximately their same percentage (see table). Since the net gain or loss of Blue Cross for a year approximates 1 to 5 per cent, it could ill afford these additional expenses, without giving consideration to the increasing number of claims that might result if the gates were opened.

A few doctors and several patients have reported their dissatisfaction with Claims Committee decisions to the Insurance Commissioner. A few have found their way to the courts. It is gratifying that only one case has been lost by the Blues on a Claims Committee decision. Always there have been good, local doctors who have been willing to review the case on an impartial basis and testify. The subscribers and the doctors as well as the Blue Plans owe them a debt of gratitude. Fortunately, it has not usually been necessary to place them on the stand since expert questioning of the plaintiff's doctor, if he went along with the case, brought an admission of the diagnostic nature of the hospitalization.

Blue Cross Rejection Study for Three Year Period

	1955		*1956*		*1957*	
Total cases processed	72,678		92,450		108,042	
Total cases rejected	3,126		4,729		5,430	
	DA	PE	DA	PE	DA	PE
Total cases rejected	169	741	350	1175	1036	1221
Per cent of rejected cases to total processed	0.2%	1.02%	0.4%	1.3%	1.0%	1.13%
Per cent of rejected cases to total rejected	5.4%	23.7%	7.4%	24.8%	19.1%	22.5%
Net gain or loss for year	+$401,000		—$117,000		+$373,000	
Per cent gain or loss for year	Gain 4.8%		Loss 1.1%		Gain 2.7%	

It is regrettable that any case must ever reach the courts. Each is likely to hurt our public and personal relations. With this in mind, for years we stayed out at all costs. Finally, it was necessary that we demonstrate that certain individuals could not force payment of unjust claims by the simple filing of a small claims suit with a $5.00 deposit. Many of these suits cost more to defend than to pay, but by successful defense the nuisance suit has been discouraged, and recalcitrant doctors have been shown that their word is not necessarily law, if it cannot be supported by fact.

Concurrent Care

Concurrent care presents a growing problem. There is an appalling lack of understanding on the part of the doctors that, with modern attitudes and expenditures patients cannot afford multiple doctors for concurrent care. Since insurance creates no new money, but only pays out what is paid in by policyholders, it cannot pay for such coverage. With multiple doctors indicated on a case, an attempt is made to pay them. When there are over-all limitations in the amount in a single hospitalization and those limitations must be considered in the payment to these doctors, it is imperative that doctors indicate when others are assisting in the care of a patient, and that they adequately describe the necessity for concurrent care. Unless this is done, it cannot be considered for payment by insurance.

Many policies are protected by simply stating that only one doctor may be paid during a hospitalization. Blue Shield has not done that. There have been numerous cases in which payment was made above the limits of the "J" Contract, because it was considered to be "necessary care." With the offering of new contracts with wider coverage, the payments of amounts in excess of the "J" Contract must be curtailed. We doctors must consider the fact that if we are to specialize in a limited field and attain unusual competence in that field, we may be able to charge larger amounts for our services. We must, however, also consider whether or not our limitations have created a demand for another doctor who would not ordinarily be on the case and who in turn will make added charges on the patient. It is possible that our values need readjustment as much as those of our patients. Let us be realistic in our approach to this problem.

Some have said that we encourage dishonesty in the recording of hospital data. That may be true, since a dishonest person, be he patient or doctor, will sometimes go to any extreme to reach his end. It is up to us of the medical profession to put a stop to such practices when they are discovered, all the more reason for the doctor to remain in this insurance field. Thus far, we have been lax in policing our ranks. Unless we are willing to do a better job of it, our minorities may be our Waterloo.

The Claims Committee was confronted with such increasing numbers of questionable claims that permission was recently secured from the Blue Shield Board to submit the worst of these to local grievance committees for their consideration. And, accordingly, we have suggested to several doctors that if they were not satisfied with the decision of the Claims Committee, they could submit their problem to the local hospital audit committee, where one exists, or to the grievance committee. Serious consideration will be given to their decisions if they demonstrate a desire to review all facts and give them their conscientious deliberation. This is another opportunity for medicine to solve its own problems. Many decisions must be based on the necessity of the hospitalization. Local groups can decide this better than distant ones IF THEY WILL, but if they refuse to accept this responsibility, government will do it for us in more ways than one.

Regimented medicine in any form is not desirable, but it has been forced upon us by changing times and our own omissions. It is part of the great "averaging" of our present civilization in that fee schedules make no allowances for competence. Fee schedules, however, seem to be a necessity for the protection of the honest and humane doctor and patient. It seems far better for us to regulate ourselves in such a way that we maintain a reasonable control over our destiny rather than have politicans and bureaucrats take us over. It is late; it is imperative that we cooperate and that we regulate, if we are to continue to practice a certain amount of free medicine.

415 Medical Arts Building.

ABSTRACTS

The Present Status of Endometriosis. By William Wickman and Timothy A. Lamphier. Postgrad. Med. 23:598-604 (June) 1958.

Although benign in every sense of pathologic interpretation, endometriosis causes extremely disabling symptoms and frequently is particularly difficult to treat. Because its incidence seems to be increasing, and since it affects relatively young women in the childbearing age and leads to considerable discomfort and disability, the authors investigated the present status of the disease by analyzing a series of 175 cases of proved endometriosis observed in several hospitals in the Boston and Miami areas. In summarizing their observations and conclusions they stated that the disease usually can be diagnosed if one suspects the possibility of its occurrence and looks for the cardinal symptom and the pathognomonic sign. The cardinal indication is the progressive accumulation of symptoms associated with the menstrual period. The pathognomonic sign is an indurated, immobile, invasive endometrioma that is tender during menstruation.

It has been emphasized that early marriage and frequent pregnancies may be an important factor in decreasing the incidence of this disease. The progress of endometriosis can be reversed by ovarian deactivation. Because the lesions of endometriosis can be seen long before they can be felt, one should be as radical about advising operation as the surgeon should be conservative about castrating when he explores the abdomen. Hormonal therapy should not be used unless the diagnosis has been confirmed by an exploratory operation. This therapy should be used only for a limited time. In general, patients less than 40 years of age should be treated by a conservative type of operation; patients more than 40 years old should be treated by more radical surgery. None of the theories advanced to explain the cause of endometriosis has been proved conclusively.

Initial Clinical Trial of the Nitrogen Mustard Analogues of Chloroquine and Quinacrine: A Preliminary Report. By Ralph Jones, Jr., Ulfar Jonsson, Melissa Browning, Howard Lessner, C. C. Price, and A. K. Sen. Ann. New York Acad. Sc. 68:1133-1150 (April 24) 1958.

Studies of the human pharmacology of nitrogen mustard analogues of the antimalarial durgs chloroquine and quinacrine conducted in patients with advanced malignant disease are here described. Chloroquine mustard administered parenterally had as its limiting toxic reaction a profound effect on the central nervous system, manifested by the production of paresthesias, toxic psychosis, and convulsions. When chloroquine mustard was administered intramuscularly in doses of 0.2 to 0.4 mg./kg., there was preliminary evidence suggestive of some chemotherapeutic activity against neuroblastoma, leukemia, and the solid lymphomas. Quinacrine mustard produced severe gastrointestinal irritation, and was probably not absorbed in an active form when administered by mouth. When administered parenterally, the limiting toxic reactions were local irritation and bone marrow depression. In patients who were treated parenterally, there was limited preliminary evidence suggestive of chemotherapeutic activity in two patients with multiple myeloma and in one patient with chronic lymphatic leukemia.

Urticaria Pigmentosa: Report of a Case with Autopsy Examination. By Robert J. Davis, M.D., and Morris Waisman, M.D. A. M. A. Arch. Dermat. 79:649-650 (June) 1959.

To authenticate the fact that the skin may be the organ exclusively involved in urticaria pigmentosa, even when of severe degree, the authors report a case of congenital urticaria pigmentosa in an infant, studied clinically and at autopsy. In this instance, although the skin was classically and maximally infiltrated with mast cells, no evidence of concomitant involvement was detected internally. The possibility that visceral or skeletal lesions of mastocytosis might have developed later in life cannot, of course, be disavowed.

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 2411, Jacksonville, for abstracting and publication in The Journal. If you have no extra reprints, please lend us your copy of the journal containing the article.

PRESIDENT'S PAGE

Time Marches On

The third and last resolution which I proposed for your consideration at the New Year was:

"FURTHER BE IT RESOLVED that we work as diligently and as constantly as our adversaries to do everything we can to preserve the freedom of our profession and also the freedom of all men."

In a very few days we will open the Eighty-Sixth Annual Meeting of the Florida Medical Association. That is the time each year that we do our most serious thinking as a group. It is the time that we most commonly make our most important decisions. It is when we approve or disapprove, accept or reject, the previous year's work and efforts of our officers, Board of Governors and various committees as well as the proposals of our component county societies. I can think of no time more appropriate for us to consider seriously the meaning of our New Year Resolution.

This is the time when we consider all of our resolutions for the year. Let us begin our eighty-seventh year well by following our New Year Resolution and completing the work of our eighty-sixth year in a positive way that becomes the dignity of our profession. The welfare of the Medical Profession is one of our trusts. A more important responsibility is the welfare of all men. Let us, as we consider our problems, think of what is best for our immediate community—our own State of Florida, our national community—the United States of America, as well as what is best for the people of the world.

If we devote our deliberations and attentions and if we work diligently always for what is best for our particular wards—the humans on this earth—we will not have to worry about what will happen to or what will happen for our profession. A grateful public will look after us as they have those before us and the medical profession will remain one of great dignity and esteem.

The time has come for me to say farewell. I hope that your retiring administration has added another rung to our ladder of progress. It has been said, "One can see far when he stands on the shoulders of his predecessors." We are deeply grateful for the help we received from those before us and we hope we have given at least a little boost for the start of your new team.

THE JOURNAL
OF THE
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Hemoglobin

Once upon a time, hemoglobin was the stuff that made blood red and, when it was low, required replenishing with iron to rid the patient of fatigue, weakness, and impotence.

From the burgeoning reports of recent years, it now appears that hemoglobin is pretty complicated stuff and can be any one or a combination of components currently designated alphabetically from A through N. Just as there are no J-birds in the Army, there is no B hemoglobin, S hemoglobin having been given this position in the hierarchy.

The hemoglobin existing in most adults and children past the age of 10 months, and therefore presumably "normal" hemoglobin, is Type A. Except as noted below, Type A hemoglobin migrates most rapidly on filter paper electrophoresis and constitutes the reference point for describing the electrophoretic mobilities of the "abnormal" hemoglobins. Type A hemoglobin can be separated further into four subcomponents by starch-block electrophoresis, A-1 being the most abundant and hence the so-far ultimate "normal." Fraction A-2 is consistently increased in thalassemia states.

Hemoglobin S is the abnormal hemoglobin found in the well known sickle cell diseases: the S-trait and S-anemia. The characteristic cell is identified by the classic sickle cell preparation and by the faster sodium metabisulfite method. S migrates less rapidly than A and more rapidly than C on electrophoresis. Recent case reports indicate that the usually innocuous S-trait can be responsible for gross hematuria, as well as for splenic infarctions during airplane flights and typical sickle cell crises after dehydration and/or anoxemia. In sickle cell anemia, recent therapeutic advances include the slow intravenous infusion of 80 to 120 cc. of *one* molar sodium lactate to abort painful crises and the maintenance of the total hemoglobin above 10 Gm. per hundred cubic centimeters by transfusions to heal lower leg ulcers.

Hemoglobin C is transmitted genetically in the same fashion as S, so that the heterozygous C-trait and the homozygous C-disease exist. The characteristic but not pathognomonic red cell of the C states is the target cell. C moves most slowly of all the hemoglobins on filter paper electrophoresis. Patients with C-trait are asymp-

tomatic. In the few reported cases of homozygous C disease the patient usually has a chronic anemia and splenomegaly, but does not have hemolytic crises.

Hemoglobin D is rare and migrates electrophoretically in the same position as S. It is differentiated from S by different solubilities in phosphate buffers and by the inability to produce sickling.

Hemoglobin E is indigenous to Thailand and environs, and, therefore, of little local importance.

Hemoglobin F or fetal hemoglobin is identified by the alkali denaturation test. It occurs normally in the newborn as 60 per cent to 80 per cent of the total hemoglobin. The concentration gradually drops and is replaced by A or other hemoglobins until it has practically disappeared, in all but a rare individual, by the age of nine or 10 months. Hemoglobin F may reappear as 5 per cent to 10 per cent of the total hemoglobin in adults suffering from severe anemias of various etiologies. It is increased particularly in sickle cell anemia and in patients with combinations of other abnormal hemoglobins, and is characteristically elevated in the thalassemia states.

It is axiomatic that a combination of two abnormal hemoglobins in a single individual confers a clinical situation more serious than the relatively innocent C or S traits but less dangerous than the homozygous S anemia. In sickle cell-C disease and microdrepanocytosis (the sickle cell–thalassemia combination), however, painful and even fatal hemolytic crises have occurred. Other reported complications include pulmonary infarctions, aseptic necroses of the femoral head, and severe anemias of pregnancy.

Hemoglobins G through N are rare, migrate faster than A electrophoretically, may impose a mild anemia on the host, and are of little clinical importance.

The fine molecular structure of three of these hemoglobins, A, S and C, have been determined. If one breaks down the globin portion of the hemoglobin molecule into its polypeptide fractions and further into its amino acid constituents, one finds that they differ in only one amino acid of the more than 300 such in each molecule. It is simply awe-inspiring to know that this difference of one molecule can determine the health and even the fate of an entire human organism.

Thus, the current investigations of the hemoglobinopathies, a tiny segment of the broad field of medicine, are bringing new light into the dark jungles of the study of human genetics, hematologic pathophysiology, and the molecular concept of disease.

BARKLEY BEIDLEMAN, M.D.

"Symptomatic Medicine"

"Symptomatic medicine" has acquired the reputation of poor medicine, of the dispensing of a series of pills to relieve a succession of complaints in a patient with an undiagnosed or incurable illness. It is generally referred to apologetically by the doctor in charge of the case, or condescendingly or scathingly by another doctor reviewing the case. Is such an attitude justified? Why should not the patient's symptoms be relieved?

The present century, because of the astounding advances in diagnostic techniques and in surgical and pharmacologic methods of cure, has witnessed a change in the goal of the medical profession. Cure of the disease, or, if that is not possible, restoration of maximum function, is now the aim, rather than alleviation of suffering while the disease runs its course in the patient. It is true that if the disease is properly diagnosed, and if a specific remedy is available and properly prescribed, then the symptoms caused by the disease will abate and eventually disappear as the disease is healed, and a change in the symptoms may be a useful gauge of the progress of the treatment.

But what of the many symptoms caused by "stress" or "tensions" or by unknown disorders? The patient may obtain some relief by learning that his headache is caused by tension or sinusitis rather than the brain tumor he feared, but he will still expect some more direct relief while awaiting the benefits of measures directed toward

the underlying condition. If such relief is not forthcoming, the less tolerant or less patient patient will seek help elsewhere—which explains why the quack and the cultist still flourish in this age of medical miracles.

One other point should be made. It is often thought that "symptomatic medicine" is easy—that the relief of a symptom is a simpler achievement than cure of a disease. This is far from true, for the proper evaluation of a symptom involves a thorough grounding not only in physiology but also in the psychology of the doctor as well as the patient, and prescribing for the symptoms presupposes an up-to-date knowledge of pharmacology.

The relief of symptoms is still the principal desire of patients coming to the physician. There should be no shame or stigma attached to granting such relief, provided the cause of the symptoms is understood. For a remarkably lucid and complete exposition on this subject the interested reader is referred to Dr. Walter Modell's monograph.[1]

1. Modell, Walter: The Relief of Symptoms, Philadelphia, W. B. Saunders Company, 1955.

J. M. P.

The Functions of an Intern And Resident Committee

In the past 10 years there has been a marked change in the thinking of the average senior medical student as he looks for the internship which best suits his needs. Formerly, most appointments were arranged by the faculty advisor, but with the development of the intern matching program, the student found that he could command greater consideration and advantages for himself as the price for his acceptance of an internship. This has led to many needed and desirable improvements in the intern's life, but has also created the intern who is entirely or primarily interested in the material benefits to be obtained during this period of his training.

Recognizing these changes and accepting the desirable and progressive ones, we continue to believe that facilities for patient management in an atmosphere of congeniality with good supervision by an interesting attending staff at an institution that provides facilities for investigative work and cares for the physical needs of the house staff will attract desirable interns.

On this premise, all senior students who contact a hospital regarding internships should be encouraged to visit and thoroughy inspect the institution. This visit should be chaperoned by a member of the house staff who has no advance notice of the visit or instructions concerning the conduct of the visit. The student should see the physical plant, learn of the nursing service, inspect the laboratory facilities, and determine the degree of supervision by the attending physician upon each service as well as the caliber of these physicians. He should observe the type and variety of clinical material, the posted on call service, the living quarters and the eating facilities, and above all—by association with his guide and the other members of the house staff with whom he comes in contact—he should *feel* the disposition of the staff.

This intangible disposition of satisfaction or dissatisfaction with one's work is most important to each prospective intern or resident, for this is the end result of a service which, recognizing its minor deficiencies, constantly tries to correct them and to achieve a satisfying and rewarding experience.

Within the administrative office questions of stipend, job opportunities for wives of the married interns, local costs of living, hospital statistics, and the policies of the administration in regard to the house staff should be answered.

Whenever possible the applicant should talk with a member of the attending staff to determine the potential of the training program in which he will undertake his first patient responsibility. The staff members contribute their services because of the enjoyment derived from teaching, and their enthusiasm can communicate itself to the applicant for internship. In turn, this contact with the young men and women of medicine is a stimulus which helps to maintain the

interest of the attending staff. The hospital intern committee should encourage this contact and perfect a program which places patient responsibility directly upon the house staff with the attending staff in an ever present advisory capacity.

The intern and resident committee should further encourage a well rounded hospital experience including facilities for experimental medicine and research. With such an organization the hospital can offer a training program rarely available except in the larger teaching centers.

Such a committee should be young enough to understand the many problems which beset the intern and to encourage free discussion of these problems. This rapport insures the rapid correction of unrest and prevents smoldering resentments which may wreck morale.

In summary, the intern who accurately assesses his hospital's potential as well as what it expects from him before making his choice is more apt to be a contented, industrious and well oriented individual. The strength of a residency program is dependent upon the caliber of interns available for residency training selection. The level of a hospital's performance is determined by the ability of the house and attending staffs and their cooperative effort.

It is the goal of the intern and resident committee to assure this effective cooperation through dedication, devotion and industry to the end that hospital staff interns and residents and the patients shall enjoy the benefits of the training program.

THAD MOSELEY, M.D.

Rehabilitation
The Third Phase of Medicine

HOWARD A. RUSK, M.D.
NEW YORK

One of the greatest advances that has been made by medicine and surgery in the past two decades is the new acceptance of a third dimension of medical and surgical responsibility—rehabilitation. There is no more eloquent testimony not only of medicine's acceptance of this responsibility, but also of the acceptance of all professions, of government at all levels, of industry, of the public and of education than the two reasons we are gathered here this week end—the new College of Health Related Services and the Rehabilitation Area of the Teaching Hospital and Clinics of the J. Hillis Miller Health Center.

Rehabilitation has frequently been termed the "third phase of medicine," following "preventive medicine" and "curative medicine and surgery." It is that period when the "fever is down and the stitches are out," the period "between the bed and the job." In contrast to "convalescence," in which the patient is left alone to let nature and time take their course, rehabilitation is a dynamic concept in which the skills of the rehabilitation team consisting of the physician, physical therapists, occupational therapists, nurses, social workers, counselors and other trained personnel are integrated as a single force to assist the patient in reaching the maximum of his physical, emotional and social and vocational potentials.

The first objective of rehabilitation is to eliminate the physical disability if that is possible; the second, to reduce or alleviate the disability to the greatest extent possible; and the third, to retrain the person with a residual physical disability "to live and to work within the limits of his disability but to the hilt of his capabilities."

Until the last 50 years, the saving of human life as the traditional and cherished goal of medicine was largely a matter of saving individual patients. With the first half of the Twentieth Century, the whole character of medicine's traditional goal was changed. The expansion of research into the etiology and therapy of communicable and infectious diseases "struck specifics."

Professor and Chairman, Department of Physical Medicine and Rehabilitation, New York University-Bellevue Medical Center, New York City; Associate Editor, The New York Times; Past President, International Society for the Welfare of Cripples; President, The World Rehabilitation Fund.

Abstract of an address delivered at the formal recognition of the College of Health Related Services and Rehabilitation Area of the Teaching Hospital and Clinics, J. Hillis Miller Health Center, Gainesville, Fla.

The establishment of new and effective public health measures and the rich findings in the basic fields reported elsewhere gave the life-saving functions of medicine mass proportions.

These combined with similar advances in greater availability of medical and hospital care, improved nutrition, increased education, better housing and all the contributing factors to our unprecedented current standard of living mean hundreds of thousands of persons are alive today who would have died at the turn of the century with the same medical problems. Yet many of them have not come out unscathed. They have survived only to find themselves confronted with residual disability. The paraplegic whose back is broken in a fall does not die today as he would have 50 years ago. He has strong arms, an active mind and a burning desire to live the best life he can with what he has left. Antibiotics control the upper respiratory and urinary infections of the severely involved cerebral palsied youngster who would have succumbed before their development. He seeks his place in society. The survivors of infection get their share of the degenerative diseases. These are present day problems which must be solved.

The day to day experience of all practicing physicians shows not only that there has been a substantial increase in the gross number of disabled persons, but also that a growing percentage of our population suffer from long term illnesses and substantial physical impairments.

During the past few years there has been a growing interest, both professional and among the public, in the development of rehabilitation services for the physically handicapped. This growth of rehabilitation services for the handicapped is a part of a total pattern of an expanding community, national and global consciousness of social welfare, which is reflected in similar advances in all educational, health, and social services.

As in all great social movements, this increased interest in rehabilitation has been a result of the impact and recognition of increased needs—in this instance, the rapid increase in the developed parts of the world of the incidence of chronic disability as a result of the increasing age of the population.

Although some nations of the world still have pressing problems of communicable disease, and life expectancy rates vary from nation to nation, depending on the availability of medical care, public health measures, food supply, and the general standard of living, the trend in all nations is toward a greatly increased life expectancy, with the result that throughout the world our population is gradually becoming older.

At the same time that the average age is advancing in the developed parts of the world, a new concept of the dignity of man and the value of the worth of the individual is beginning to emerge in those nations of the world which do not have the benefits as yet of modern programs of public health and medical care. This new concept of the worth of the individual has been symbolized, and is finding its expression in many instances in the desire of these nations to institute programs of services for their physically handicapped.

Rehabilitation has been defined as the ultimate restoration of the disabled person to his maximum capacity—physical, emotional, social and vocational. Implicit in this definition is the need for a team whose members can bring together a wide variety of skills and understandings. No one profession can furnish all the services needed. Rehabilitation is, rather, an area of specialized activity within a number of professional disciplines.

The Physician's Responsibility

Until recent years, the great majority of the medical profession looked upon rehabilitation as an extracurricular activity of medicine, something dealing with social work and vocational training, but something which they had little concern, and which held but few implications for medicine. Today, however, that trend is being reversed, and although there are still many physicians who are unfamiliar with the aims and procedures of rehabilitation, more and more medicine is beginning to recognize that medical care cannot be considered complete until the patient with a residual physical disability has been trained "to live and work with what he has left." Except in a few isolated instances, the physically handicapped person must be retrained to walk and travel, to care for his daily needs, to use normal methods of transportation, to use ordinary toilet facilities, to apply and remove his own prosthetic devices and to communicate either orally or in writing. These are such simple things that they are frequently overlooked, but the personal, vocational, and social success of the handicapped person is dependent upon them.

The practice of rehabilitation for the general practitioner, for the orthopedic surgeon, or for

any doctor, begins with the belief in the basic philosophy that the doctor's responsibility does not end when the acute illness is ended or surgery completed; it ends only when the individual is retrained to live and work with what is left. This basic concept of the doctor's responsibility can be achieved only if rehabilitation is considered an integral part of medical services. Any program of rehabilitation is only as sound as the basic medical and surgical service of which it is a part. The diagnosis and prognosis must be accurate, for it is upon them that the feasibility of retraining is determined.

Rehabilitation Services in Hospitals

Although some outstanding rehabilitation programs in various parts of the world have demonstrated that rehabilitation to the point of self care and even to full or limited employment is possible for many of the chronically ill who have been hospitalized for long periods, patients in few hospitals receive comprehensive rehabilitation service. Hospitals complain that the chronically ill are responsible for their overcrowded state, but few of them provide the third phase of medical care which will permit many of these patients to leave the hospital.

It is only within the general hospital that such services can be brought to the patient at the earliest possible time, and costly and damaging physical, emotional, social and vocational sequelae of the acute disease process or trauma be alleviated or minimized.

To ignore the development of rehabilitation services within general hospitals is to guarantee the continued deterioration of many less severely disabled persons until they, too, reach the severely disabled and totally dependent category. The neglect of disability is far more costly than an early aggressive program of rehabilitation which restores the individual to the highest possible level of physical, economic, social and emotional self sufficiency.

Nearly 14 years of experience in the first comprehensive rehabilitation in a general civilian hospital (Bellevue Hospital, New York City) together with extended observation and study of other general hospitals indicate that rehabilitation services within the hospital can best be provided by the organization of a "bed service" which has a relationship to the other hospital services similar to that of the x-ray and laboratory divisions.

For example, in Bellevue Hospital the rehabilitation service provides consultants for such other major services as orthopedics, pediatrics, surgery, and neurology. Its resident and visiting staff regularly makes rounds with the resident and visiting staff of these services. Its staff may, for example, see a patient in consultation before his leg is removed, indoctrinating him as to what he must expect, why he cannot keep his stump on a pillow, why he has to lie on his abdomen. Medical responsibility during the period of definitive care, of course, rests with the initial or admitting service. As soon as the stitches are removed, the patient is transferred to a rehabilitation ward. At this time, the rehabilitation service assumes the major responsibility for his care, fitting of the prosthesis, and training in its uses. The roles are now reversed; the surgical service has become the consulting service.

Prior to the actual transfer of the patient to a rehabilitation ward, however, he attends one of the rehabilitation service's semiweekly evaluation clinics, where his problem is analyzed and discussed by all members of the staff—physical therapists, occupational therapists, nurses, vocational counselors, speech therapists, social workers and psychologists—as well as resident and visiting medical staff. The decision as to the feasibility of transferring the patient to the rehabilitation service is then made on the basis of the service's ability to contribute to his over-all physical, emotional, social and vocational rehabilitation.

Rehabilitation during the first quarter of the century was characterized by the development of orthopedic surgery, physical therapy, and occupational therapy, all outgrowths of World War I. Under the stimulus of World War II, the second quarter of the century has seen a recognition that the problems medicine faces in meeting the growing incidence of chronic disease and disability extend far beyond any medical specialty; they are problems which must be faced and solved by medicine as a whole. The concept of rehabilitation and the basic techniques must be made a part of the armamentarium of all physicians, for regardless of the type of disability, the responsibility of the physician to his patient cannot end when the acute injury or illness has been cared for. Medical care is not complete until the patient has been trained to live and to work with what he has left.

If any major attack is to be made on the problems of chronic disability, the general hospital

and the individual practicing physician must be the focal points of that attack. It is only in doctors' offices and in general hospitals that such services can be brought to the patient at the earliest possible time and that the costly and damaging physical, emotional, social and vocational sequelae of the acute disease process or trauma may be alleviated or minimized.

Rehabilitation of the chronically ill and the chronically disabled is not just a series of restorative techniques—it is a philosophy of medical responsibility. Failure to assume this responsibility means to guarantee the continued deterioration of many less severely disabled persons until they, too, reach the severely disabled and totally dependent category. The neglect of disability in its early stages is far more costly than an early aggressive program of rehabilitation which restores the individual to the highest possible level of physical, economic, social and emotional self sufficiency.

The new College of Health Related Services and the Rehabilitation Area of the Teaching Hospitals and Clinics of the J. Hillis Miller Health Center will make a significant contribution not only in Florida, but throughout the Southeast, nationally and internationally to the more widespread practice of the philosophy of rehabilitation.

400 East Thirty-Fourth Street (16).

Midwinter Seminar Of Ophthalmology and Otolaryngology A Popular Attraction

The fourteenth annual Florida Midwinter Seminar of Ophthalmology and Otolaryngology was held at the Americana Hotel in Bal Harbour, Miami Beach, from January 24 to January 30, 1960. Again this year there was an unusually large number of registrants from throughout the nation with about 350 physicians in attendance. These physicians represented about 45 states, the District of Columbia and several provinces of Canada. Florida had the largest delegation with 78 physicians present, and the state of New York was a close second. There were heavy representations from the other Northern states as well as from the Midwest. A small number of registrants came even from the far Western states including California.

This year the first three days were devoted to ophthalmologic papers and the last three days to otolaryngologic papers. In between the interesting papers there were over 20 interesting exhibits to be studied. All of the 30 papers presented were of great interest to the doctors in attendance, and a large amount of unpublished material was presented.

In the section on ophthalmology, Dr. Bernard Becker, of St. Louis, reported on his findings in glaucoma, a field in which he has performed over 40,000 electrotonographic examinations. He presented strong evidence indicating that glaucoma is inherited, with it being detected in about 15 per cent of patients who had members of their family with glaucoma. He also discussed some of the newer medicines, both miotics and secretory inhibitors, and their use in treating glaucoma.

Dr. David G. Cogan, of Boston, gave an excellent presentation on what examinations of the eye tell about systemic diseases and how their recognition and prognosis can be aided by the ophthalmologist.

Dr. Robert N. Shaffer, of San Francisco, led interesting discussions on the use of the gonioscope as well as diagnosis and treatment of congenital and secondary glaucomas.

Dr. Joseph A. C. Wadsworth, of New York, presented many interesting facets of little known vitreous syndromes as well as the difficult diagnostic criteria of macular lesions.

Dr. Frank B. Walsh, of Baltimore, discussed numerous neuro-ophthalmologic subjects relating to bilateral sudden blindness and muscle palsies and also presented special selected case reports.

In the otolaryngologic section Dr. Howard P. House, of Los Angeles, presented the most startling data in his discussion of the inner ear. It has been shown that dihydrostreptomycin is toxic and has brought about some cases of incurable nerve deafness. It is his recommendation that dihydrostreptomycin not be used at all, and he reported that it had been taken off the market by many of the drug houses.

Dr. Merle Lawrence, of Ann Arbor, Mich., presented several talks on the physiology of hearing, to the edification of all present.

Dr. Joseph H. Ogura, of St. Louis, discussed many new and interesting facets of head and neck surgery in relation to cancer of the larynx, pharynx, and esophagus.

Dr. Maurice H. Cottle, of Chicago, presented several new aspects of rhinitis and sinusitis with

especially a new premaxilla-maxilla approach in septum surgery.

Dr. Lawrence Boies, of Minneapolis, discussed some of the indications for sinus surgery as well as neurologic lesions in otolaryngology.

After this most interesting week's meeting, the doctors returned to their respective homes well rested and enlightened and looking forward to an even more interesting program next winter.

T. S. E.

Sixth Biennial Cardiovascular Seminar Set for April 27-30 at Miami Beach

The Sixth Biennial Cardiovascular Seminar will be held at the Balmoral Hotel on Miami Beach April 27 through 30, 1960, Wednesday through Saturday. It will again be cosponsored by the Heart Association of Greater Miami, the Florida State Board of Health, and the Florida Heart Association. In conjunction with the Seminar will be the Annual Meeting of Membership, and the Staff Conference of the Florida Heart Association, also set for the Balmoral.

Seminar hours have been set from 9:00 in the morning until 2:00 in the afternoon to allow registrants, participants, and their families to enjoy the beach in the spring. Sixth in the series begun in 1950, the Seminar is expected to reach a record attendance, with a roster of 13 of the world's outstanding men in the field of cardiovascular disease.

The faculty includes Dr. E. Grey Dimond, Professor and Chairman of the Department of Medicine at the University of Kansas Medical Center, and Director of the Cardiovascular Laboratory there; Dr. Harriet P. Dunstan of the Cleveland Clinic, well known for her contributions to research in the field of hyptertension and a member of the American Heart Association Council for Hypertension Research; Dr. William T. Foley, Associate Professor of Clinical Medicine at Cornell University College of Medicine, and noted for his many contributions in the field of anticoagulants; Dr. Charles K. Friedberg, Senior Attending Physician and Chief of Cardiology at Mt. Sinai Hospital in New York City, editor of the textbook "Diseases of the Heart" and of the publication, "Progress in Cardiovascular Disease," and on the Editorial Board of "Circulation" magazine.

Other members are Dr. Dwight E. Harken, Surgeon and Chief of the Department of Thoracic Surgery at Mt. Auburn and Malden Hospitals in Boston, Surgeon to the Peter Bent Brigham Hospital in Boston, and Consultant in Thoracic Surgery to the Veterans Administration Hospitals in Massachusetts, and a Founder of the Board of Thoracic Surgery; Dr. John B. Hickam, Professor and Chairman of the Department of Medicine at the Indiana University Medical Center; Dr. Robert M. Hosler, Associate Director of courses in Cardiac Resuscitation at the New York Academy of Medicine and in Cleveland, and author of a well known manual on cardiac resuscitation; Dr. Bernard Lown of the Harvard University School of Public Health where he is currently Associate in Medicine in the Department of Nutrition at Harvard and Peter Bent Brigham Hospital; and Dr. James Metcalfe of the Boston Lying-In Hospital and Assistant Professor of Medicine at the Harvard Medical School.

Additional faculty members are Dr. Clark H. Millikan of the Mayo Clinic, Professor of Neurology of the Mayo Foundation, Graduate School, University of Minnesota; Dr. Eugene A. Stead, Jr., Chairman of the Department of Medicine at the Duke University School of Medicine, and Physician-In-Chief at the Duke Hospital in Durham; Dr. Demetrio Sodi-Pallares, Chief of the Department of Electrocardiography at the National Institute of Cardiology in Mexico City, and Professor of the Cardiovascular Clinics at the National University of Mexico; and Dr. W. Jape Taylor, Assistant Professor of Medicine at the College of Medicine of the University of Florida, and member of the Board of Directors and the Professional Education Committee of the Florida Heart Association.

Physicians are urged to register promptly with the Heart Association of Greater Miami, 2 S. E. 13th Street, Miami 32, Florida. The registration fee for the Seminar will be $25.00, which will not include luncheons, separately priced at $3.00 each. Registrants from outside the Miami area who wish may make reservations at the Balmoral Hotel, and will be given a special rate for the duration of the Seminar, including two days before and two days after. At the time of registration, each participant will have the opportunity to specify which of the discussion groups he wishes to participate in. Luncheons each day will feature a two hour panel, during which members of the morning's faculty will answer questions from the audience.

Dedication Ceremonies For New Research Building

"Town and gown are partners in medical education," Dr. John H. Talbott said in his dedicatory address for the new Research Building of the University of Miami School of Medicine on March 3. Under a gala tent, an audience of more than a thousand Miamians interested in medical education heard Dr. Talbott outline the responsibilities of organized medicine to medical education and the relationships which should be realized through this partnership.

After Dr. Talbott's talk, R. B. Gautier Jr., former Florida senator, replied to the challenge and expressed the hope that the great medical potential of Miami would be realized and that the medical school, now past its infancy, would develop into one of the world's great medical centers.

Mr. Gautier spoke for the Council of the School of Medicine, a group of prominent Miami business and professional leaders who are seeking to raise funds for the completion of the perma-

Dr. John H. Talbott, principal speaker at the dedication, and Editor of The Journal of the American Medical Association.

Dr. John C. Finerty, Chairman of the Department of Anatomy, checks condition of animals moved to the new research building from temporary warehouses.

New Research Building, University of Miami School of Medicine.

nent buildings of the school. A new basic science building to replace the temporary facilities leased from the Veterans Administration Hospital in Coral Gables is the council's first objective.

The Research Building, located at 1600 N.W. 10th Avenue, Miami, is part of the Metropolitan Medical Center. It has been under construction since May 1958, and contains 90,000 square feet of laboratory space. The building cost over two million dollars to build and another quarter of a million dollars to equip. The funds were obtained from the United States Public Health Service and from Dade County and University sources.

The School of Medicine now has 150 research projects under way, with grants of more than two million dollars annually for their support. Many of these projects have had to be housed in temporary and inadequate quarters all over Dade County. Warehouses, old barracks buildings and empty stores have all been pressed into service. Each department of the School of Medicine has been looking forward to the facilities now available in the modern, air-conditioned, spacious structure. The building is designed so that it may be joined to a future basic science building, to be constructed when funds are available.

Daniel J. Mahoney, chairman of the University of Miami Board of Trustees, presided at the dedication ceremonies. Brief statements were made by Dr. Jay F. W. Pearson, President of the University, and Dr. Homer F. Marsh, Dean of the School of Medicine. Also introduced were Mr. Francis Schmehl, representing the Department of Health, Education, and Welfare, Mr. Ben McGahey, Chairman of the County Commissioners of Dade County, and Hoke T. Maroon, Miami banker and chairman of the Medical School Council.

The dedication ceremonies were planned by a committee of almost 100 people, under the chairmanship of Dr. Robert B. Lawson, Professor and Chairman of the school's Department of Pediatrics. Mr. Maroon was co-chairman. Other members of the planning committee were: Program, Dr. Ralph Jones Jr., Professor of Medicine, and Judge Ray Pearson; Printing, Dr. William B. Deichmann, Professor of Pharmacology; Invitations, Dr. George T. Lewis, Professor of Biochemistry and R. B. Gautier Jr.; Arrangements, Dr. W. A. D. Anderson, Professor of Pathology; Exhibits, Dr. David S. Howell, Assistant Professor of Medicine; Hospitality, Mrs. James H. Ferguson and Mrs. Herman Boughton; Guides, Mrs. Fred F. Ravlin; and Hostesses, Mrs. Karl Slotta. Members of the Medical School Council served on all committees. The theme set for the dedication was Research Is the Key to Tomorrow. Guides and hostesses wore large gilt keys as emblems, and keys were used to decorate the exhibit and luncheon areas inside the building.

Dr. Gordon C. Ring, Chairman of the Department of Physiology, adjusts electronic equipment newly received for electrophysiology research.

More than 60 women took special training courses in order to be able to act as guides. The University faculty and staff were given a guided preview of the new building on March 2. Following the dedication ceremonies tours through the building were provided for the general public and during the week, several thousand people came through. Radio and television stations in the Miami area announced the hours of the tours frequently during the week prior to the dedication, and the School of Medicine used the opportunity to show visitors what kinds of new research projects are under way.

Palm Beach County Medical Society Health Fair

The Palm Beach County Medical Society felt strongly that the ever increasing amount of health information in magazines, newspapers and television commercials today points to three important facts:

1. These news releases place before the public information of intimate interest and appeal.
2. They present confusing and often contradictory opinions on diagnoses and treatments.
3. They bring to the attention of the medical profession the tremendous need for general health education.

Two main mediums through which the public can be reached by the medical profession are health forums, which have proved to be popular and well attended, and health fairs. The advantages of health fairs over any other form of communication are being shown with each exhibit sponsored on a professional level.

Health fairs are a relatively new method of disseminating health information for the enlightenment of the general public, and the January 1960 Fair sponsored by the Palm Beach County Medical Society is the first such effort in Florida and the third in the nation. When the Palm Beach County Medical Society decided to have a Health Fair, it had two important decisions to make: (1) where to hold it, and (2) who should participate. It considered space available, ease of access and, most important, how to reach the greatest number of people. The considered decisions gave this exhibit the distinction of being the first Health Fair held in conjunction with a County Fair; the first to be held in a tent, with 8,000 square feet of exhibit area; and the longest run of any health fair up to this time, nine days.

Exhibits were set up in tents in keeping with the atmosphere of the County Fair.

Inside the tent exhibits were set up on either side of a wide aisle. Note the use of platforms as the foundation for all exhibits.

Sixteen voluntary and official health organizations were invited to participate along with the allied medical groups which included the Palm Beach County Dental Society, Palm Beach County Veterinary Society, Palm Beach Pharmaceutical Society, and District 9 Nurses' Association. The voluntary and official organizations included: Palm Beach County Health Department, Visiting Nurse Association of Palm Beach County, American Cancer Society, Palm Beach County Blood Bank, Palm Beach County Assocation for Retarded Children, Palm Beach County Chapter National Foundation, Rehabilitation Center for Adults and Children, Palm Beach County Society for Crippled Children & Adults,

Palm Beach County Mental Health Association, Palm Beach County Tuberculosis & Health Association, Heart Association of Palm Beach and Martin Counties, Glaucoma Detection Clinic, Vocational Rehabilitation Service, Good Samaritan Hospital, St. Mary's Hospital, Florida Alcoholic Rehabilitation Program, Florida Council for the Blind, and Palm Beach County Chapter, American Red Cross.

One of the special features of this fair was the emphasis on careers in medicine and the allied medical sciences. Tours for high school students were an important part of the plan to convey information on career opportunities in the health fields. Free services offered included blood typing, chest x-rays, and a glaucoma detection survey which attracted crowds lined out to the midway. These services were strategically located to offer ample opportunity for all to take advantage without causing congestion in the general exhibit area. Among the 28 exhibits shown were those obtained from the American Medical Association, the Cleveland Health Museum, the United States Public Health Service, the United States Department of Agriculture, the Florida State Board of Health and other agencies.

In the initial planning for the Health Fair, the Palm Beach County Medical Society appointed a Health Fair Committee composed of chairmen of all major medical society committees; subcommittees to handle exhibit review, publicity review and doctor recruitment were selected. At the outset of planning a coordinator was appointed to take care of the many details involved in such an undertaking. This was Mrs. Ivan Schmidt, a member of the Medical Society's Auxiliary, who originally suggested the idea of the Health Fair. The importance of the coordinator cannot be stressed too strongly, because without such a person it would be impossible to carry out a project of this magnitude successfully. Valuable assistance in planning was received from the American Medical Association, the Florida Medical Association, the Florida State Board of Health and the Columbus (Ohio) Academy of Medicine.

The success of this project can be measured by the large attendance throughout the hours of operation which were 10 a.m. to 10 p.m. during the nine days of the exposition. Between 50 and 60 thousand people passed through the exhibits. The state and national interest which has been shown in this fair along with tremendous local enthusiasm is further indication of the value of this activity in furthering public relations and health education.

In planning this fair the importance of avoiding commercialism was emphasized, and an informative and scientific approach was stressed. The satisfaction and results of this undertaking are more than compensating for the effort involved.

CLARENCE L. BRUMBACK, M.D., *Chairman*
HEALTH FAIR COMMITTEE
PALM BEACH COUNTY MEDICAL SOCIETY

Florida Association of Blood Banks Holds Annual Meeting in Clearwater May 13 - 15, 1960

The annual meeting of the Florida Association of Blood Banks will be held at the Fort Harrison Hotel in Clearwater on May 13-15, 1960. An outstanding program has been planned by Dr. Lloyd R. Newhouser, President-Elect and the chairman of the Program Committee, and is as follows:

FRIDAY, MAY 13, 1960

8:30 p.m. Annual Business Meeting

SATURDAY, MAY 14, 1960

9:00 - 9:15	Welcome Address Dr. Walter H. Winchester, President-Elect, Pinellas County Medical Society
9:15 - 9:40	Licensing and Inspection of Blood Banks John T. Tripp, Ph.D., National Institutes of Health
9:40 - 10:15	Hemosiderosis Jacob Neber, M.D., Mount Sinai Hospital, Miami Beach
10:15 - 10:45	Discussion and view exhibits
10:45 - 11:15	Lions, Ostriches and Sheep Robert Klein, M.D., Blood Bank, College of Medicine, University of Florida, Gainesville
11:15 - 11:45	Transfusions and Hepatitis John R. Neefe, M.D., St. Petersburg Medical Clinic, St. Petersburg

2:00 - 2:30 Method for Checking Technician Crossmatches
D. B. Rulon, M.D., U. S. Naval Hospital, Key West
2:30 - 3:00 The Present Status of Bone Marrow Transfusions
James N. Patterson, M.D., Tampa
3:00 - 3:15 Exhibits
3:15 - 3:35 Disaster
Louis E. Pohlman, M.D., and Mary Rand, Central Florida Blood Bank, Orlando
3:35 - 4:00 Allergic Transfusion Reactions (A Review)
John B. Ross, M.D., Jacksonville Blood Bank, Jacksonville
4:00 - 4:20 Donor and Recipient Immunizations
Ed Landry, Laboratory Supervisor, John Elliott Blood Bank, Miami
4:20 - 4:45 Normal and Abnormal Platelets
Lloyd R. Newhouser, M.D., John Elliott Blood Bank, Miami

SUNDAY, MAY 15, 1960
9:00 - 10:00 Business Meeting
10:00 - 12:00 Round table discussion on Blood Bank Administration
Panel: Al Bloomingdale, Chairman, Miami; Carol Wilson, Jacksonville; Quinn Jordan, Phoenix, Ariz.; R. E. Hunter, Clearwater; and R. P. Tew, M.D., Lakeland
10:00 - 12:00 Technical Panel: Lloyd R. Newhouser, M.D., Chairman, Miami; John B. Ross, M.D., Jacksonville; Robert Klein, M.D., Gainesville; James J. Griffitts, M.D., Miami; Jacob Neber, M.D., Miami Beach; and Ed Landry, Miami

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Recognition Ceremonies University of Florida Rehabilitation Program

The Director of the Federal Office of Vocational Rehabilitation early in February termed the University of Florida's J. Hillis Miller Health Center "the most promising innovation in the development of national services for handicapped people." Miss Mary E. Switzer, keynoting recognition ceremonies for the newly established College of Health Related Services and Rehabilitation Area of the Teaching Hospital and Clinics, described the Health Center as "an outstanding example of the pattern of rehabilitation services and training of tomorrow."

"Here," Miss Switzer said, "you have planned and developed a unified program for training professional rehabilitation personnel on the basis of a brilliantly conceived and well-thought-out plan. At the same time, you are providing rehabilitative services to disabled people who need help in order to become active, working, producing citizens."

Miss Mary E. Switzer, Director of the Federal Office of Vocational Rehabilitation.

The formal recognition ceremonies were a highlight of a two day conference at the Health Center on February 5 and 6 with physicians, rehabilitation counselors, and professional people from other health-related professions on hand from throughout the United States. On Friday, February 5, the group heard Dr. Howard A. Rusk, Director of the Institute for Physical Medicine and Rehabilitation at New York University—Bellevue Medical Center.

Dr. Rusk said that the general hospital and the individual practicing physician must be the focal point of any future attacks on chronic dis-

Dr. Darrel J. Mase, Dean of the College of Health Related Services, University of Florida; Dr. Howard A. Rusk, Director of the Institute of Physical Medicine and Rehabilitation at New York University-Bellevue Medical Center; Dr. Alfred R. Shands Jr., Medical Director of the Alfred I. duPont Institute of the Nemours Foundation; and Dr. George T. Harrell, Dean of the College of Medicine, University of Florida (from left).

ability. "Neglect of disability in its early stages is far more costly than an early aggressive program of rehabilitation which restores the individual to the highest possible level of physical, economic, social and emotional self-sufficiency," he said.

Dr. Rusk, past president of the International Society for the Welfare of Cripples and currently president of the World Rehabilitation Fund, called rehabilitation the third phase of medicine —following "preventive medicine" and "curative medicine and surgery." He said one of the greatest advances that has been made by medicine and surgery in the past two decades is the new "acceptance of a third dimension of medical and surgical responsibility—rehabilitation."

Presiding over the activities was Dr. Russell S. Poor, provost of the Health Center. On hand to greet the visitors was Dr. Harry M. Philpott, vice president of the University of Florida. Prior to Miss Switzer's address, Dean Darrel J. Mase of the College of Health Related Services introduced his staff and the chairmen of the curricula in physical therapy, occupational therapy, medical technology and rehabilitation counseling.

Seemingly tremendously impressed with the Health Center and its facilities, Miss Switzer, who holds the top government position in rehabilitation, said, "This entire concept and the actual situation of the schools and the rehabilitation area is unique in our country and in the world. Here for the first time in history we have the basic rehabilitation teaching and service facilities under one roof and in close juxtaposition to all others that impinge upon the field. I consider this a great and most beneficial symbol of the future development of the services of rehabilitation."

Miss Switzer said the Office of Vocational Rehabilitation is proud of its support of the planning and development of the center and predicted that "the pattern you have laid out and put in practice here will be a guide to those who, as Florida has done, desire first to find out what is needed, then to proceed and meet that need in the most efficient manner possible."

"It should be heartening to all who want to help in overcoming the appalling burden of disability to observe what is done here. We have talked for years about the necessity for teamwork in rehabilitation. Here we have a built-in guarantee of continuing teamwork," the speaker said.

"The students in medicine, nursing, physical therapy, occupational therapy and rehabilitation

counseling are brought together from the beginning of their studies," Miss Switzer continued. "Each learns early the value and the function of the other. This inevitably will result in greater understanding among the members of the various professions and will engender the highest respect of each discipline for the skills and value of practitioners of the others.

"To the group which had the vision, first, to conceive and then to carry out this splendid effort, I tender not only the gratitude of the entire rehabilitation community but the unstinted admiration and applause."

Grants for Special Studies in Cancer

The application of existing knowledge of preventing and controlling cancer is being given added impetus this year through $1,500,000 appropriated by the Congress, the Public Health Service pointed out recently. This fund, earmarked for community cancer demonstration projects, is being administered by the Cancer Control Program, Bureau of State Services, Public Health Service, under the technical guidance of the director of the National Cancer Institute.

The types of projects believed to offer the best opportunities at this time for demonstrating better ways of providing community cancer control services are:

1. Professional and technical education in cytology.

2. Screening female beneficiaries of medical care for cancer of the cervix.

3. Selected educational projects, particularly public information and follow-up services, to emphasize the importance of periodic uterine cytology examinations.

4. Professional educational activities emphasizing the importance of including cancer diagnostic aids in complete health examinations.

5. Selected public educational projects on the desirability of and need for health maintenance examinations.

6. Evaluation of effectiveness of public educational activities.

7. Tumor registers collecting data of exceptional value.

8. Extension and evaluation of rehabilitation programs (in cooperation with state rehabilitation agencies).

9. Selected projects demonstrating effective treatment for cancer in public beneficiaries of medical care.

The types of projects suggested are not meant to exhaust all possibilities. Other worth while locally sponsored and locally directed demonstration projects will be considered on their own merits.

Applications are accepted from nonprofit organizations and institutions and official health agencies. The appropriate state health officer and Public Health Service regional medical director are first to review and process applications. The requests are then submitted to the Advisory Committee to the Cancer Control Program and the National Advisory Cancer Council for recommendation of approval or disapproval. Formal action on applications and recommendations is taken by the chief of the Bureau of State Services, to whom authority has been delegated by the Surgeon General.

Projects may be approved initially for as long as three years. When activities are proceeding satisfactorily and funds are available, assistance continues through the approved period. In special instances, assistance may include the assignment of personnel and the provision of equipment and supplies. Additional information and application forms may be obtained from the eight regional offices of the Public Health Service.

OTHERS ARE SAYING

The Challenge of the Rising Population

Medical practice with all its skills has done well by the community in the prolongation of life. The increasing population obviously indicates the need for a constantly increasing number of physicians. To whom shall we look for leadership in this growth in our ranks? Shall it be the medical schools? Shall it be our rising 18-year olds who will in some twenty short years be the leaders of the future? It will be at best a complex problem, but one in which each medical society on the local level must acknowledge some responsibility.

Before our students come to the medical school level they must make good at college. The United States Department of Education reports that there are a large number, some 25 per cent in the average freshman class, who join the sad stream of "drop-outs" before June . . . bitter, frustrated, and bewildered. There are many reasons why these

young people do not stick, and it is with these reasons that we physicians must come to grips. If we are to look to this pool of personnel for our replenishment we must know that the youngsters matriculating have shown a gradually increasing I.Q. in the past 10 years as measured by college entrance examinations. Educators have come to the conclusion that the source of the trouble is psychological. We, therefore, cannot dismiss this matter in an off-hand manner as if we had poorer material with which to work.

In the various avenues of our contacts with people in the home, the P.-T.A., young people's groups, or in our office practice, we can be a force for good by advising parents and youngsters alike that the problem is remedial. Aside from financial problems and aside from the problem of the girl who dropped out because of marriage, there still remains a group of unmotivated students who have been insufficiently prepared in high school. Whatever may be laid at the door of the school may be charged up to the home even more certainly.

There is often the case of too much spoon-feeding and of having too much done at home before arrival at college. Overprotection at home, as well as family insistence on a distasteful career to the student, soon lets our hoped for recruit bog down in the midst of his college years. The newness of being away from home and making his own decisions calls for a measure of maturity and adjustability that parents must anticipate and offer training.

Social pressures at college may set up a competitive force against studies that develops anxiety and tension in the attempt to make good in both fields. We as physicians must take a more determined stand in advising our college population and their families in educational matters, particularly in the psychological area. We have an obligation to our profession, to our country and to our youth to make this fact known: that while the harshness of life has been mitigated, the need for learning the "skill to study" still is with us. If the practice of medicine is to keep pace with the rising population, we must have skilled and educated replacements in our ranks. We must encourage the pool of our 18-year olds to develop a dedicated and motivated attitude toward schooling. We must urge every boy and girl to continue in school, but more than this, to develop their God-given capacity to the fullest. The strength and numbers of our medical ranks can only be filled as our present 18-year olds make their finest contributions to the professional ranks of medicine.

Ben Glaser, M.D.
Quarterly Bulletin
Orange County Medical Society
April, May, June, 1959.

BLUE SHIELD

Service Benefits Approved for Federal Employees

The decision has been made. The members of the House of Delegates are to be commended for promptly diagnosing the necessity for a service benefit program of professional services for federal employees in Florida and their families, for making it possible for these employees to have a choice between Blue Shield–Blue Cross and the indemnity program to be offered through the insurance industry. Now it becomes the responsibility of doctors of medicine in the state to make certain that the voluntary way proves to be as efficient and effective as the profession has maintained that it would be, that it provides a quality of medical care possible only under freedom from strangling restrictions.

In view of the favorable action by the House of Delegates, the Board of Governors has requested Blue Shield to make available to federal employees in Florida service benefit contracts on the two levels of benefits required by law. One of these offerings is to provide full service benefits for covered expenses to families with annual incomes of $6,000, or under $4,000 for one person contracts. The lower level is to be based on a $4,000 family income, $3,000 for single persons. Professional fees for the respective levels of benefits are to be computed on the relative value schedule now being utilized for the Blue Shield 'A' contract, adjusted to the applicable income level.

To some there is the scent of victory in the air. It must be kept in mind, however, that this nip and tuck contest is by no means over. The proponents of voluntary measures for providing against the costs of illness will do well to remain alert for the next moves of the social planners in this national game or game of nationalization. Devotees of the pigskin pastime contend that it is difficult to gain yardage unless one retains possession of the ball. On other occasions the medical profession has found itself in position for

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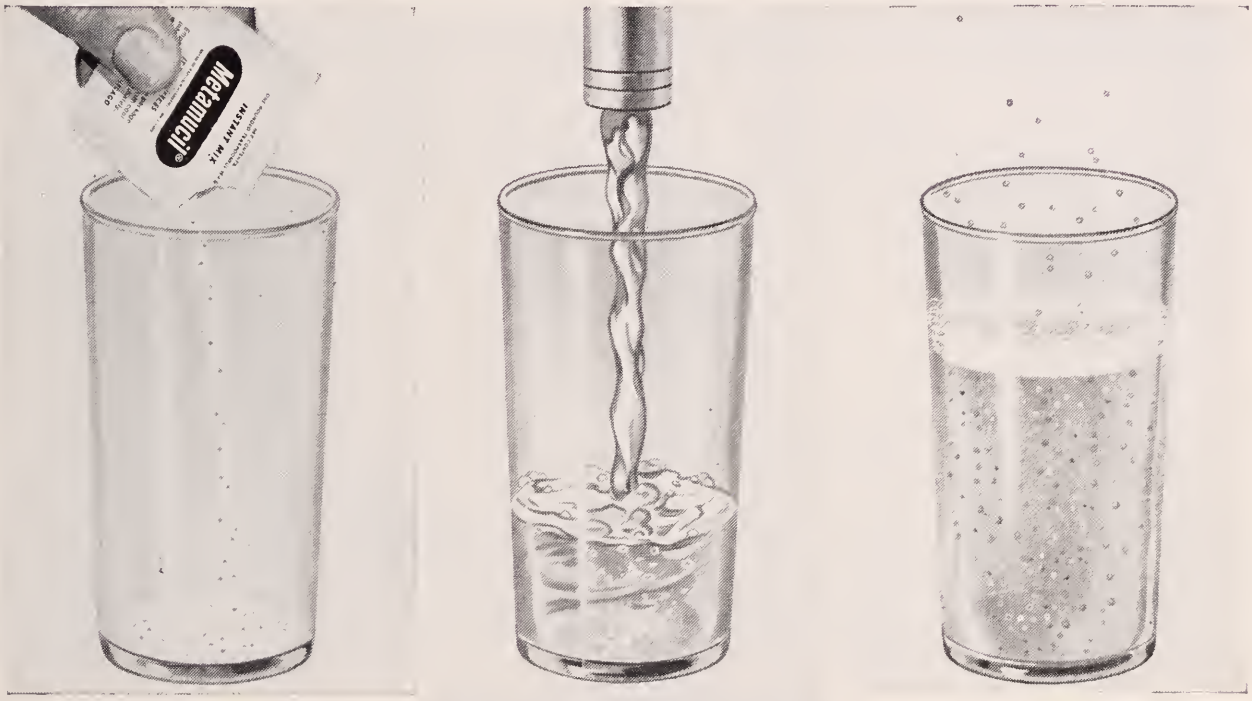

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an early score, suddenly only to have its ball carriers tackled behind the lines and its passes intercepted. Armchair quarterbacks have not hesitated to direct attention to inferior coaching, inexperienced quarterbacking, misinterpreted signals. and costly fumbles.

Uncle Sam has taken the medical profession at its collective word. He has acceded to its persistent predictions that a voluntary system will give better protection and provide higher quality medical care than any program of compulsion. Our esteemed Uncle has tossed the ball, but it is certain that he intends to see that the rules are enforced. It can be expected that he will make every effort to be reasonable and fair, but we also know that he can be a tough official. If it becomes necessary, he will not hesitate to invoke penalties, or even to declare the game forfeited. Fumbles and foul play are likely to prove fatal.

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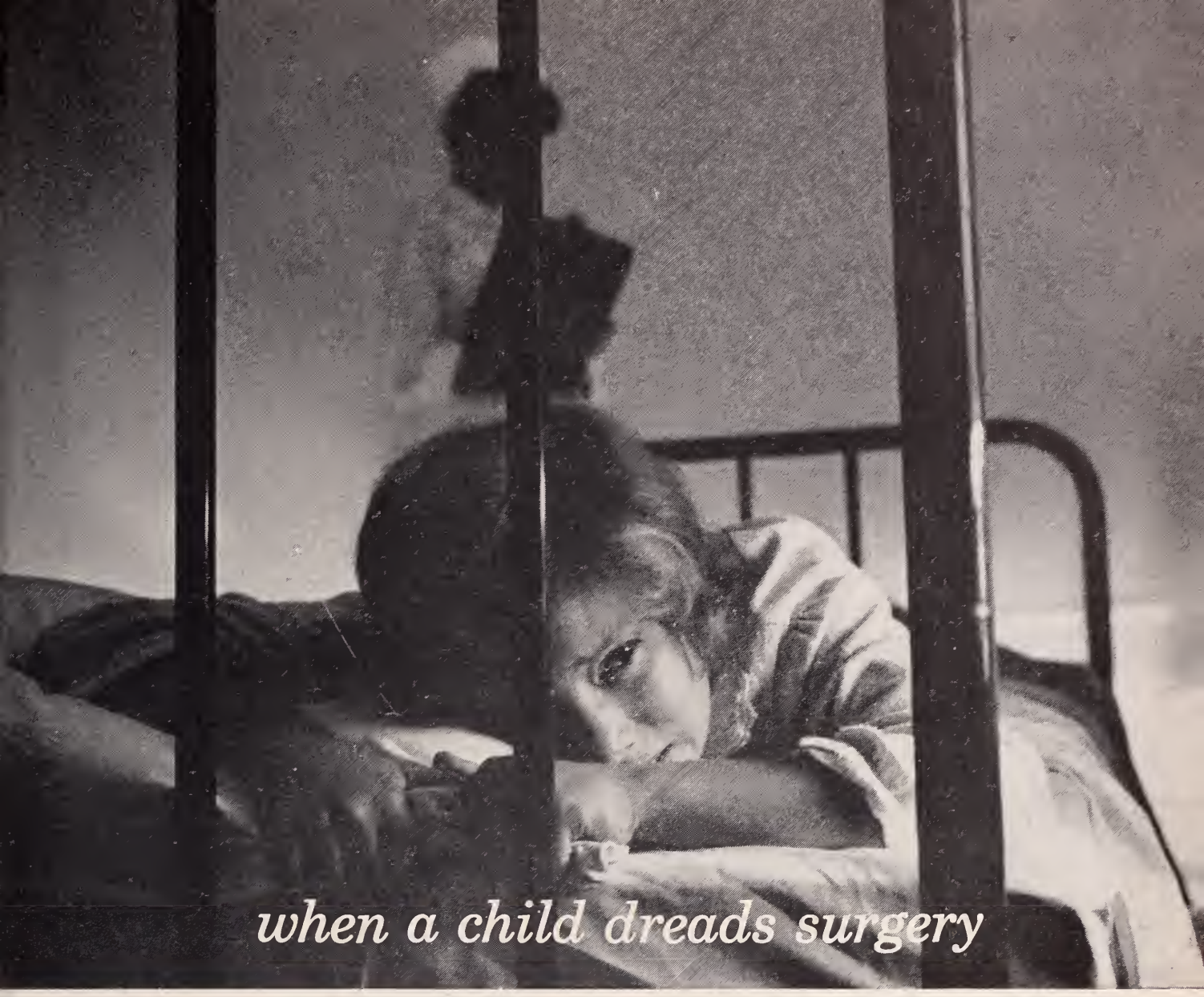

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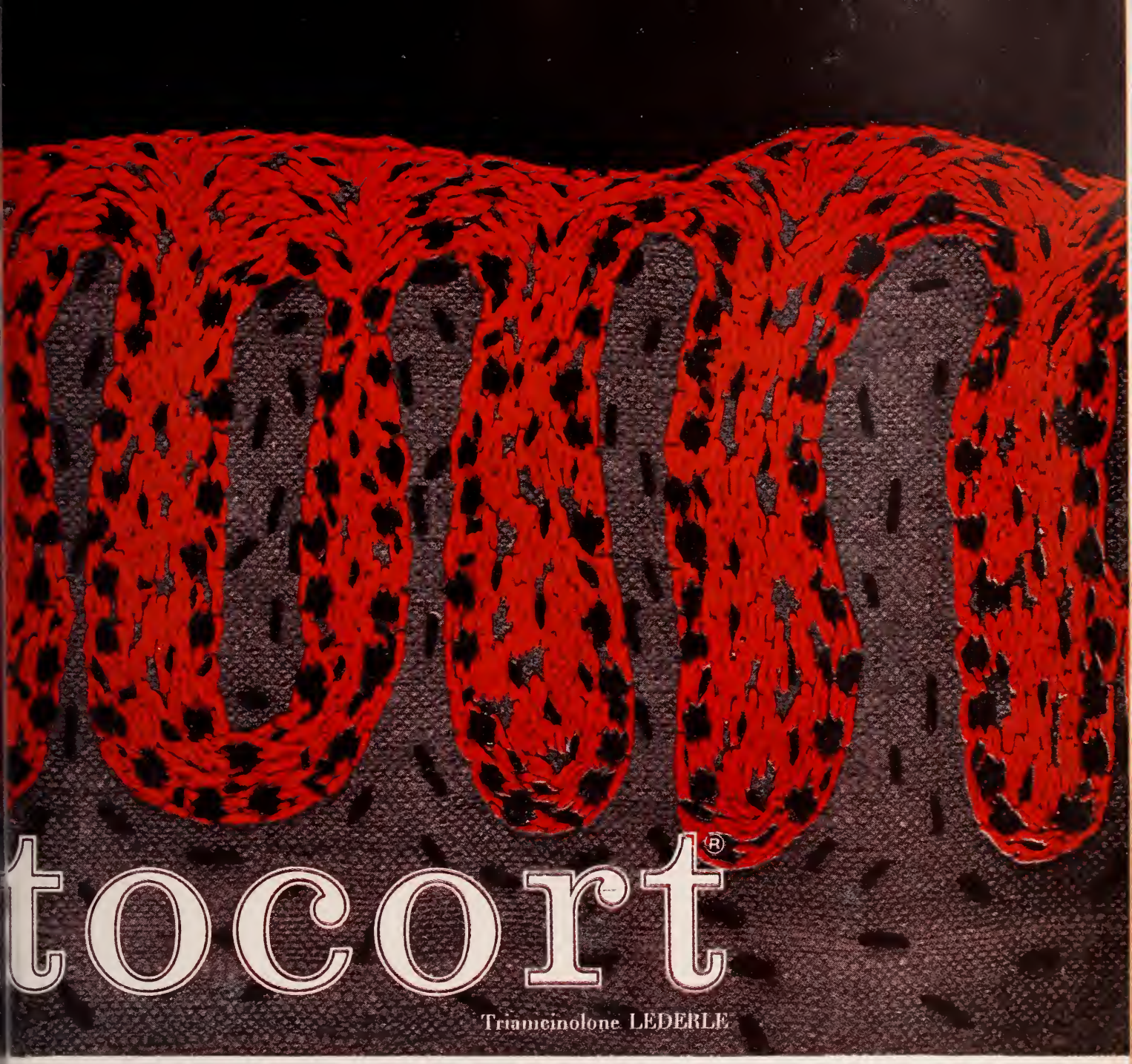

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References: 1. Feinberg, S. M.; Feinberg, A. R., and Fisherman, E. W.: *J.A.M.A.* 167:58 (May 3) 1958. 2. Epstein, J. I., and Sherwood, H.: *Conn. Med.* 22:822 (Dec.) 1958. 3. Friedlaender, S., and Friedlaender, A. S.: *Antibiotic Med. & Clin. Ther.* 5:315 (May) 1958. 4. Segal, M. S., and Duvenci, J.: *Bull. Tufts N.E. Medical Center* 4:71 (April-June) 1958. 5. Segal, M. S.: Report to the A.M.A. Council on Drugs, *J.A.M.A.* 169:1063 (March 7) 1958. 6. Hartung, E. F.: *J. Florida Acad. Gen. Practice* 8:18, 1957. 7. Rein, C. R.; Fleischwager, R., and Rosenthal, A. L.: *J.A.M.A.* 165: 1821 (Dec. 7) 1957. 8. McGavack, T. H.: *Clin. Med.* (June) 1959. 9. Freyberg, R. H.; Berntsen, C. A., and Hellman, L.: *Arthritis & Rheumatism* 1:215 (June) 1958. 10. Hartung, E. F.: *J.A.M.A.* 167:973 (June 21) 1958. 11. Zuckner, J.; Ramsey, R. H.; Caciolo, C., and Gantner, G. E.: *Ann. Rheumat. Dis.* 17:398 (Dec.) 1958. 12. Appel, G.; Tye, M. J., and Leibsohn, E.: *Antibiotic Med. & Clin. Ther.* 5:716 (Dec.) 1958. 13. Kalz, F.: *Canad. M.A.J.* 79:400 (Sept.) 1958. 14. Mullins, J. F., and Wilson, C. J.: *Texas J. Med.* 54:648 (Sept.) 1958. 15. Shelley, W. B.; Harun, J. S., and Pillsbury, D. M.: *J.A.M.A.* 167:959 (June 21) 1958. 16. DuBois, E. L.: *J.A.M.A.* 167:1590 (July 26) 1958. 17. McGavack, T. H.; Kao, K. T.; Leake, D. A.; Bauer, H. G., and Berger, H. E.: *Am. J. M. Sc.* 236:720 (Dec.) 1958. 18. Council on Drugs: *J.A.M.A.* 169:257 (January) 1959.

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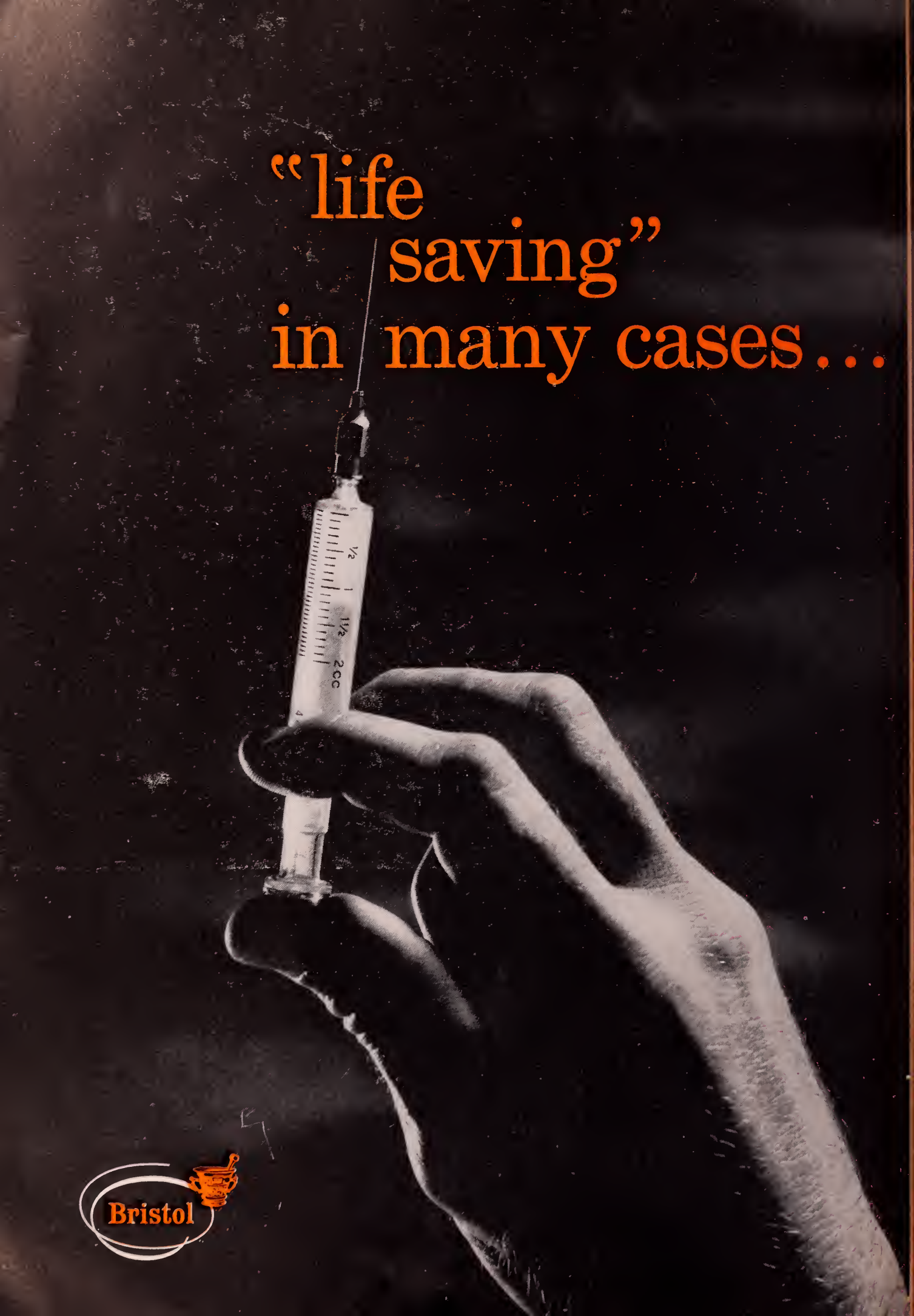
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REFERENCES: 1. Yow, E. M.: Practitioner 182:759, 1959. 2. Yow, M. D., and Womack, G. K.: Ann. N. Y. Acad. Sci. 76:363, 1958. 3. Bunn, P. A., Baltch, A., and Krajnyak, O.: Ibid. 76:109, 1958. 4. Council on Drugs, J.A.M.A. 172:699, 1960.

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STATE NEWS ITEMS

Dr. Leo M. Wachtel of Jacksonville, President-Elect of the Florida Medical Association, was principal speaker at the meeting of Region Two, American Animal Hospital Association, in Jacksonville early in February. The title of Dr. Wachtel's address was "People Who Live in Glass Houses Shouldn't."

Dr. William R. Stinger of Tallahassee has been appointed Assistant Director of the Dade County Department of Public Health. He was formerly director of the Florida Crippled Children's Commission.

Dr. Louis M. Orr of Orlando, President of the American Medical Association; Dr. James N. Patterson of Tampa; Dr. Erasmus B. Hardee of Vero Beach; Dr. Homer L. Pearson Jr. of Miami, and Dr. George T. Harrell of Gainesville were among the physicians from Florida attending the recent Annual Congress on Medical Education and Licensure held in Chicago.

Dr. Richard V. Reiswig has been elected president of the Duval County Chapter of the Florida Academy of General Practice. Dr. A. MacKenzie Manson will serve as vice president, Dr. Anson J. Mellion as secretary-treasurer and Dr. Charles H. Burke as new director. All are from Jacksonville.

"Diagnostic Problems and Recent Advances in Cancer Therapy" was the principal scientific subject discussed at the fourth annual seminar of the Watson Clinic in Lakeland on March 5. Guest participants included Dr. Gould A. Andrews, Oak Ridge, Tenn.; Dr. William R. Arrowsmith, New Orleans; Dr. William W. Daniel, New York City; Dr. Lester R. Dragstedt, Gainesville; Dr. Joseph H. Pratt, Rochester, Minn., and Dr. Julian M. Ruffin, Durham, N. C.

Dr. William J. Knauer Jr. of Jacksonville presented his film entitled "Surgical Removal of a Dislocated Lens" at the recent Pan-American Association of Ophthalmology held in Caracas, Venezuela.

Dr. James N. Patterson of Tampa has been reappointed as chairman of the Committee on

Porphyrins of the American Society of Clinical Pathologists. Recently Dr. Patterson and Dr. Charles Catanzaro of Tampa, a member of the Committee, presented a two day Tutorial Workshop on Porphyrins for pathologists from surrounding states and from the North. One other Workshop is to be presented during April.

The fifth medical seminar cruise sponsored by Duke University School of Medicine will begin June 5 and terminate on June 28 in Hamburg, Germany. The cruise ship T. S. Ariadne may be boarded June 5 at Wilmington, N. C., or on June 8 at New York City. Points of interest will include the Baltic, Le Havre, Cruxhaven, Leningrad, Helsinki, Stockholm, Copenhagen and Hamburg. Shipboard lectures will be given on various subjects in medicine, pediatrics and thoracic surgery. Information on the cruise may be obtained from Dr. W. M. Nicholson, Professor of Medicine and Assistant Dean in Charge of Postgraduate Education, Duke University Medical Center, Durham.

Dr. Jere W. Annis of Lakeland, Immediate Past President of the Florida Medical Association, was one of the principal speakers at the recent Annual Conference of County Medical Society Presidents and Secretaries sponsored by the South Carolina Medical Association at Columbia.

The forty-fifth session of the Trudeau School of Tuberculosis and Other Pulmonary Diseases has been scheduled for June 6-24 at Saranac Lake, N. Y. All inquiries should be addressed to the secretary of the School, Box 500, Saranac Lake, N. Y.

Dr. Harry Prystowsky of Gainesville, Professor and Chairman of the Department of Obstetrics at the College of Medicine, University of Florida, has been selected by the United States Junior Chamber of Commerce as one of the ten outstanding young men in the nation.

Drs. Edward H. Williams and Samuel Gertman of Miami and Dr. H. Phillip Hampton of Tampa participated in the program of the Regional Conference on Aging, sponsored by the American Medical Association, in Atlanta March 7-8. Dr. Williams, a member of the Committee on Aging of the American Medical Association,

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discussed "Medicine's Blueprint for the New Era of Aging;" Dr. Gertman, chairman of the Committee on Aging of the Florida Medical Association, was a member of the panel on "Prevention in Meeting the Challenge," and Dr. Hampton, a member of the Committee on Indigent Care of the American Medical Association, discussed "The Community's Financial Responsibility."

Dr. Fernando Rubio Jr. of St. Petersburg and Dr. Philip B. Paty of Dunedin conducted the monthly clinico-pathology session of the Mease Clinic on February 26. The subject was myelomata.

Dr. William T. Williams of Dunedin participated in the program of the Twenty-Eighth Annual Assembly of the Southeastern Surgical Congress held March 21-24 in New Orleans. The opening day of the Assembly, Dr. Williams presented an address entitled "Gastrectomy in the Patient Over Sixty."

Physicians from Florida attending the Regional Conference on Aging sponsored by the American Medical Association in Atlanta March 7-8 included Dr. Reuben B. Chrisman Jr. of Coral Gables, member of the Council on Medical Service, American Medical Association; Dr. George W. Karelas of Newberry, chairman of the Subcommittee on Health and Medical Care, Governor's Citizens Advisory Committee on the Aged; Dr. Louis L. Amato of Fort Lauderdale, member of Committee on Aging, Florida Medical Association, and Dr. Howard W. Carter of St. Petersburg, Pinellas County Health Department.

Dr. John J. Fisher of Jacksonville has been elected president of the newly organized Jacksonville Obstetrical and Gynecological Society. Other officers include Dr. Richard W. McDowell, president-elect, and Dr. Doris N. Carson, secretary-treasurer. At the initial formal meeting of the Society late in February, Dr. Nickolson J. Eastman, Professor and Chairman of the Department of Obstetrics and Gynecology at the Johns Hopkins University School of Medicine, was guest speaker. His subject was the timing of repeat cesarean section.

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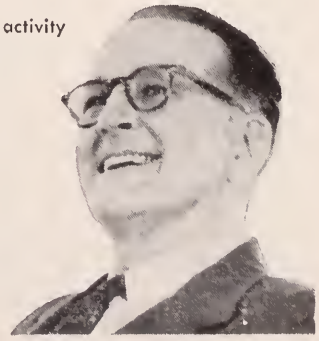

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You will soon receive in your mail a handmade, four-color three-dimensional figure of this Chinese Immortal, mounted and suitable for framing.

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COMPONENT SOCIETY NOTES

Dade

Lt. Gilbert J. Haas of the Miami Fire Department Rescue Squad was principal speaker at the March meeting of the Dade County Medical Association. As president of the Dade County Rescue Association, Lt. Haas presented information about this new group and explained the facilities of first aid and emergency units available to physicians.

Duval

A panel discussion entitled "From the Cradle to—" was the feature of the March meeting of the Duval County Medical Society. Members of the panel included Drs. Leslie R. Adams, William E. Faris, William M. Madison Jr., and James B. Strachan Jr., all of Jacksonville.

Hillsborough

Drs. John C. Fletcher and Lawrence Kahana of Tampa discussed "Medical and Surgical Aspects of Thyroid Disease," and Dr. Irving M. Essrig "Problems of Blue Shield" at the March meeting of the Hillsborough County Medical Association.

DeSoto-Hardee-Glades

Dr. James O. Ferguson of Sarasota was principal speaker at the March meeting of the DeSoto-Hardee-Glades County Medical Society held at Arcadia. Dr. Ferguson's subject was hiatus hernia.

Polk

Professor Kenneth L. Black of the University of Florida, Gainesville, discussed "Estate Planning" at the March meeting of the Polk County Medical Association held at Winter Haven.

BIRTHS AND DEATHS

Births

Dr. and Mrs. William M. Madison Jr. of Jacksonville announce the birth of a daughter, Margaret Stockton, on January 28, 1960.

Dr. and Mrs. Thomas H. Gouchnour of Jacksonville announce the birth of a daughter, Carolyn Elsie, on January 22, 1960.

Deaths — Members

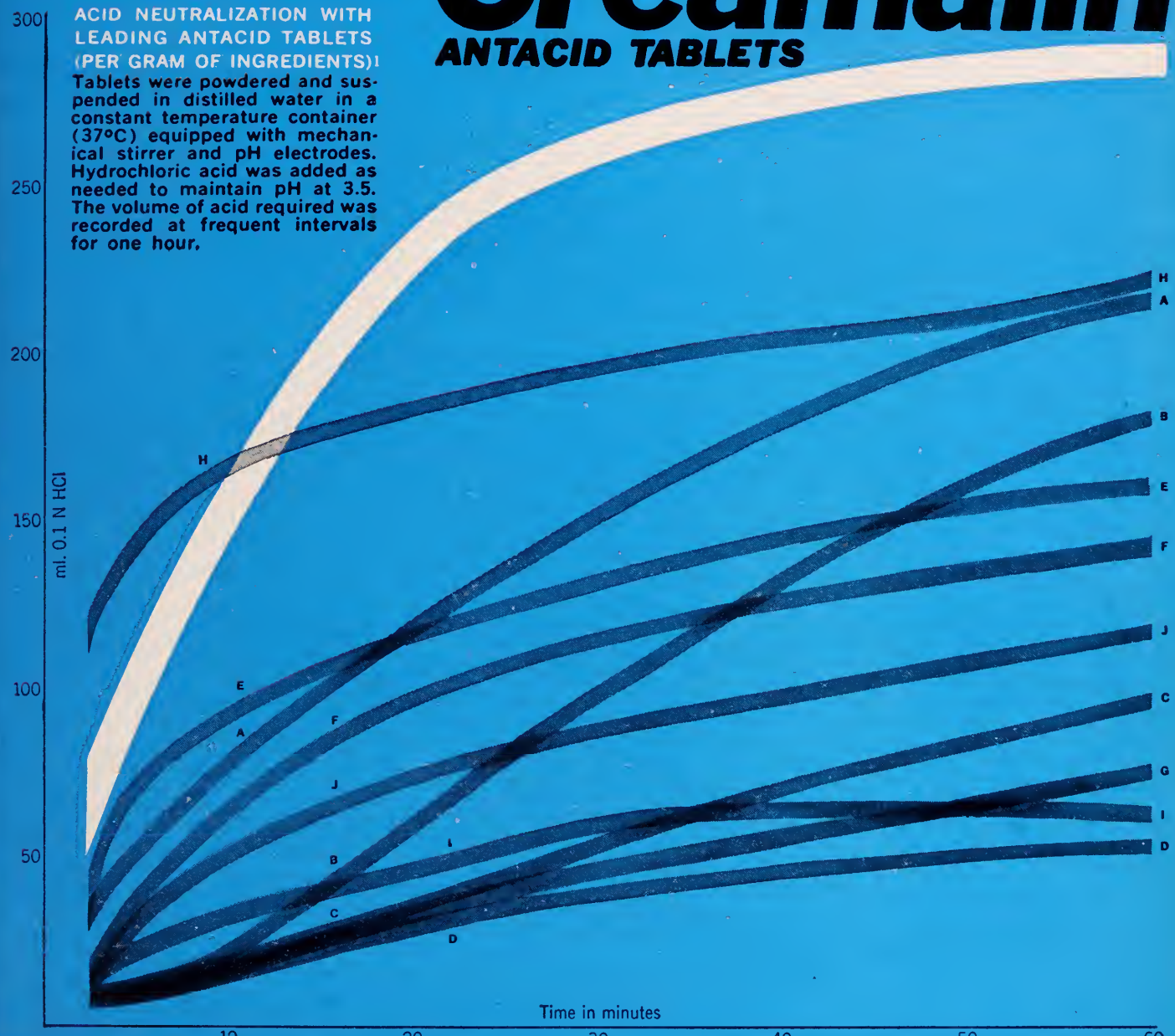
Alexander, Morris James, Punta Gorda ...October 28, 1959
Davis, Julius C., Quincy .....February 26, 1960

Deaths — Other Doctors

Cohen, Harry M., Miami Beach.....October 30, 1959
Hicks, Joseph H., Gainesville .....October 23, 1959
Quillian, Willard W., Neptune Beach....November 5, 1959

More gastric acid neutralized faster...with new Creamalin®

ANTACID TABLETS



GREATLY HEIGHTENED REACTIVITY to acid characterizes the action of New Creamalin Antacid Tablets.[1,2] They act faster and longer than other leading tablets and neutralize considerably more acid.[1] These tablets provide virtually the same effects as a liquid[2] with the convenience of a tablet. New Creamalin tablets give faster, greater and more prolonged relief.

NOT CONSTIPATING, New Creamalin Antacid Tablets will not produce "acid rebound" or alkalosis. They have a pleasant taste.

Creamalin, trademark reg. U. S. Pat. Off.

EACH NEW CREAMALIN ANTACID TABLET contains 320 mg. of specially processed, highly reactive, short polymer dried aluminum hydroxide gel (stabilized with hexitol), with 75 mg. of magnesium hydroxide.

Adult dosage: Gastric hyperacidity—2 to 4 tablets as necessary. Peptic ulcer or gastritis—2 to 4 tablets every two to four hours. Tablets may be chewed, swallowed whole with water or milk, or allowed to dissolve in the mouth.

How Supplied: Bottles of 50, 100, 200 and 1000.

1. Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: *J. Am. Pharm. A. (Scient. Ed.)* 48:380, July, 1959. 2. Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: *J. Am. Pharm. A. (Scient. Ed.)* 48:384, July, 1959.

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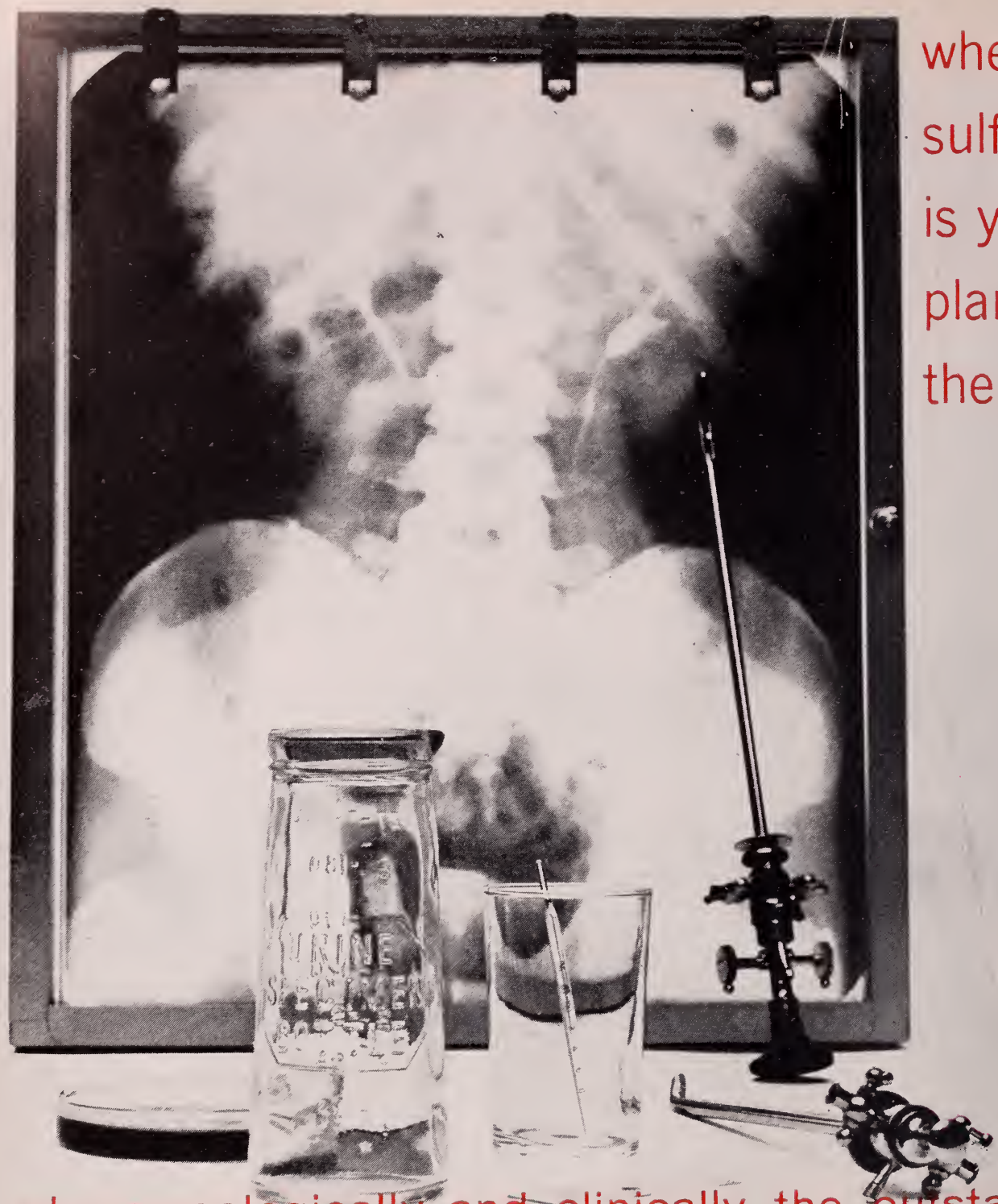
New York 18, N. Y.

FOR PEPTIC ULCER • GASTRITIS • GASTRIC HYPERACIDITY



when sulfa is your plan of therapy..

pharmacologically and clinically the outstanding

Rapid peak attainment — for early control — KYNEX® Sulfamethoxypyridazine reaches peak plasma levels in 1 to 2 hours[1,2] . . . or approximately one-half the time of other once-a-day sulfas.[2] Uninterrupted control is then sustained over 24 hours with the single daily dose . . . through slow excretion without renal alteration.

High free levels — for dependable control — More efficient absorption delivers a higher percentage of sulfamethoxypyridazine — averaging 20 per cent greater at respective peaks than glucuronide-conversion sulfas.[2] Of the total circulating levels, 95 per cent remains in the fully active, unconjugated form even after 24 hours.[3]

Extremely low toxicity[4] . . . only 2.7 per cent incidence in recommended dosage — Typical of KYNEX relative safety, toxicity studies[5] in 223 patients showed TOTAL side effects (both subjective and objective) in only six cases, all temporary and rapidly reversed. Another evaluation[4] in 110 patients confirmed the near-absence of reactions when given at the recommended dosage. High solubility of both free and conjugated product[6] obviates renal complications. No crystalluria has been reported.

Successful against these organisms: streptococci, staphylococci, E. coli, A. aerogenes, paracolon bacillus, Gram-negative rods, pneumococci, diphtheroids, Gram-positive cocci and others.

1. Boger, W. P.; Strickland, C. S., and Gylfe, J. M.: Antibiotic Med. & Clin. Ther. 3:378, (Nov.) 1956. 2. Boger, W. P.: Antibiotics Annual 1958-1959, New York, Medical Encyclopedia, Inc., 1959, p. 48. 3. Sheth, U. K.; Kulkarni, B. S., and Kamath, P. G.: Antibiotic Med. & Clin. Ther. 5:604 (Oct.) 1958. 4. Vinnicombe, J.: Ibid. 5:474 (July) 1958. 5. Anderson, P. C., and Wissinger, H. A.: U. S. Armed Forces M. J. 10:1051 (Sept.) 1959. 6. Roepke, R. R.; Maren, T. H., and Mayer, E.: Ann. New York Acad. Sc. 60:457 (Oct.) 1957.

once-a-day sulfa . . .

NOTE: Investigators note a tendency of some patients to misinterpret dosage instructions and take KYNEX on the familiar q.i.d. schedule. Since one KYNEX tablet is equivalent to eight to twelve tablets of other sulfas, even moderate overdosage may produce side effects. Thus, the single dose schedule must be stressed to the patient.

KYNEX Tablets, 0.5 Gm., bottles of 24 and 100. Dosage: Adults, 0.5 Gm. (1 tablet) daily, following an initial first day dose of 1 Gm. (2 tablets).

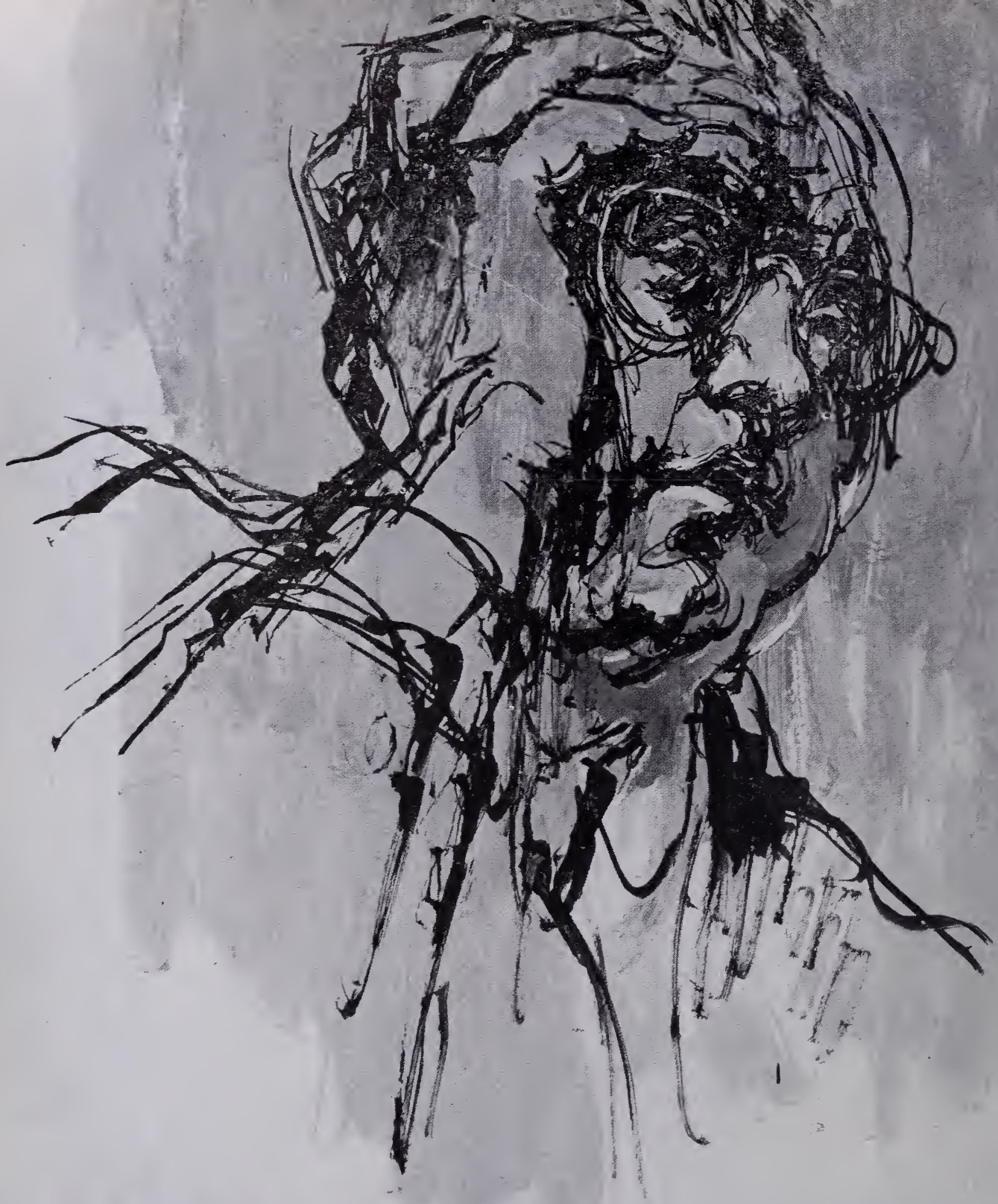
KYNEX Acetyl Pediatric Suspension, cherry-flavored, 250 mg. sulfamethoxypyridazine activity per teaspoonful (5 cc.). Bottles of 4 and 16 fl. oz. Recommended Dosage: Children under 80 lbs.: 1 teaspoonful (250 mg.) for each 20 lb. body weight, the first day, and ½ teaspoonful per 20 lb. per day thereafter. For children 80 lbs. and over: 4 teaspoonfuls (1.0 Gm.) initially and 2 teaspoonfuls daily thereafter. Give immediately after a meal.

KYNEX®

Sulfamethoxypyridazine Lederle

NEW—for acute G.U. infection AZO-KYNEX® Phenylazodiaminopyridine HCl—Sulfamethoxypyridazine Tablets, contains 125 mg. KYNEX in the shell with 150 mg. phenylazodiaminopyridine HCl in the core. Dosage: 2 tablets q.i.d. the first day; 1 tablet q.i.d. thereafter.

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York Lederle



When blood pressure **must** come down

When you see symptoms of hypertension such as dizziness, headache, and fainting your patient is a candidate for Serpasil-Apresoline. Even when single-drug therapy fails, Serpasil-Apresoline frequently can bring blood pressure down to near-normal levels, reduce rapid heart rate, allay anxiety.

SUPPLIED: Tablets #2 (standard-strength, scored), each containing 0.2 mg. Serpasil and 50 mg. Apresoline hydrochloride; Tablets #1 (half-strength, scored), each containing 0.1 mg. Serpasil and 25 mg. Apresoline hydrochloride.

SERPASIL®-APRESOLINE®
hydrochloride (reserpine and hydralazine hydrochloride CIBA)

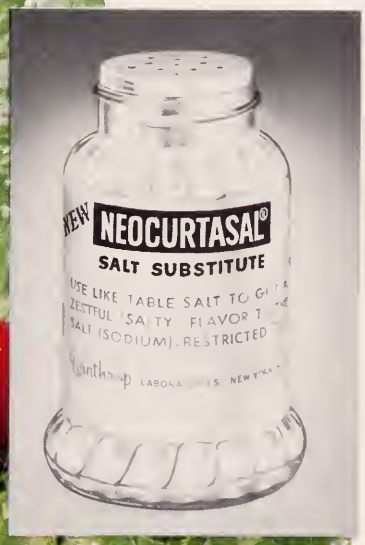
CIBA
SUMMIT, N. J.

NO SALT... *but seasoned*

A meal of even the most colorful and the most meticulously prepared food can be dreary without salt. Neocurtasal, for the patient on a low sodium diet, brings back flavor to food and makes eating a pleasure once more. Neocurtasal is also valuable for preventing potassium deficiency (weakness, etc.) in patients on diuretic therapy with chlorothiazide or its derivatives.

Neocurtasal®

An excellent salt replacement for Salt Free (LOW SODIUM) *Diets*



Neocurtasal contains potassium chloride, potassium glutamate, glutamic acid, calcium silicate and potassium iodide (0.01 per cent)

Supplied in 2 oz. shakers and 8 oz. bottles.

Sold Only through Drugstores

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New York 18, N. Y.

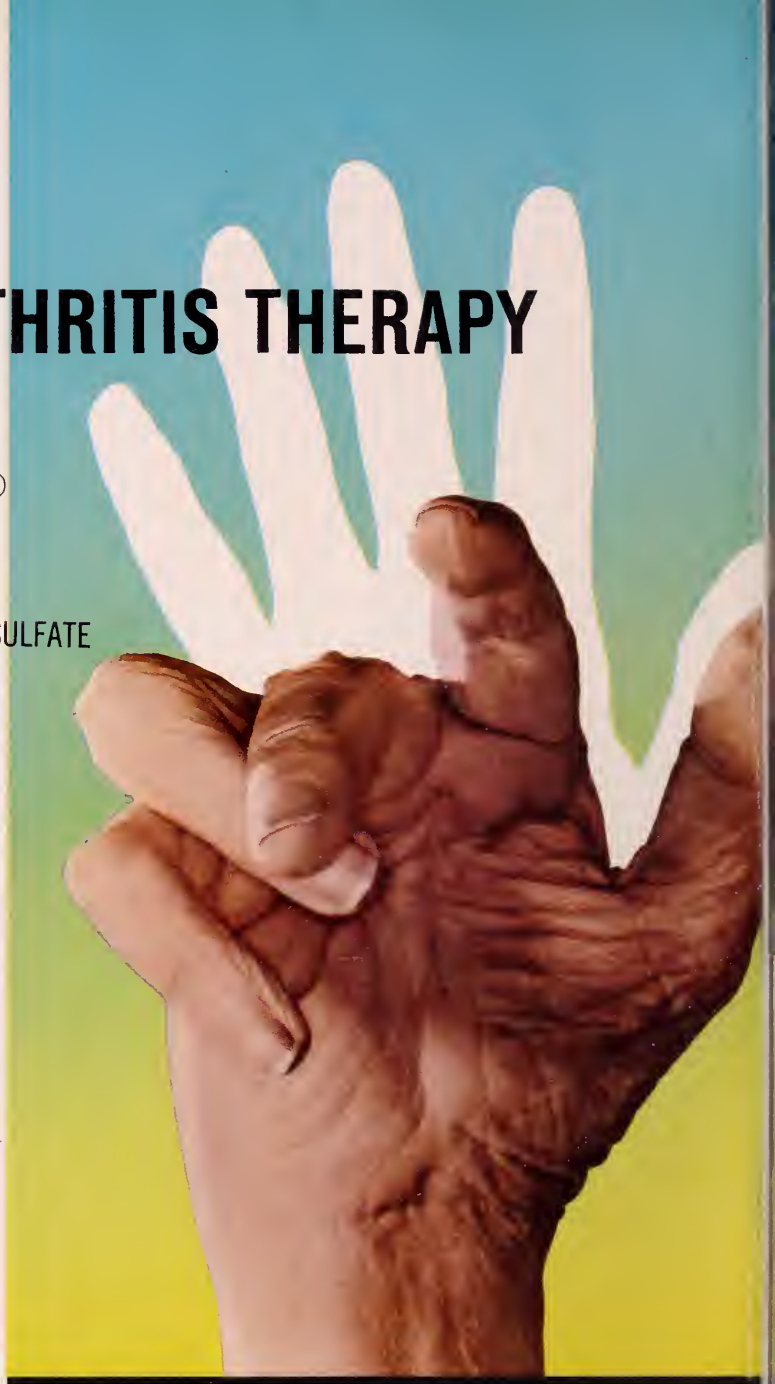
Neocurtasal, trademark reg. U.S. Pat. Off.

MAINSTAY

OF RHEUMATOID ARTHRITIS THERAPY

Plaquenil® SULFATE

Brand of hydroxychloroquine sulfate



New Long Term Chemotherapy of RHEUMATOID ARTHRITIS

"Whatever else may be needed from time to time in the management of individual cases, these drugs [Plaquenil and Aralen] should always be given a prolonged trial (at least six months) as the 'mainstay' of therapy."

Bagnall, A. W. (Univ. British Columbia, Vancouver, B.C.): A.M.A. Clinical Meeting (Scientific Section, Exhibit No. 124), Minneapolis, Minnesota, Dec. 2-5, 1958.

"The 4-aminoquinoline drugs (Plaquenil and Aralen) together with supplemental agents administered in nontoxic doses effectively maintained suppression of the disease in 83 per cent of 194 patients followed for 18 months."

Scherbel, A. L.; Harrison, J. W., and Atdjian, Martin: Cleveland Clin. Quart. *25:95, April, 1958.*

"When used in tolerated dosage and over a sufficient period of time, there appears to be a tremendous therapeutic potential in the antimalarial drugs. . . . Plaquenil in this study did not have as many side effects as Aralen and thus appears to be a more practical compound."

Cramer, Quentin (Kansas City): Missouri Med. *55:1203, Nov., 1958.*

Plaquenil is the hydroxy derivative of Arale and is available as Plaquenil sulfate in tablets of 200 mg. (bottles of 100).

Average Dosage:

INITIAL—400 to 600 mg. (1 tablet 2 or 3 times daily)

MAINTENANCE—200 to 400 mg. (1 tablet once or twice daily)

Write for Plaquenil booklet discussing clinical experience, dosage, tolerance, precautions, etc., in detail.

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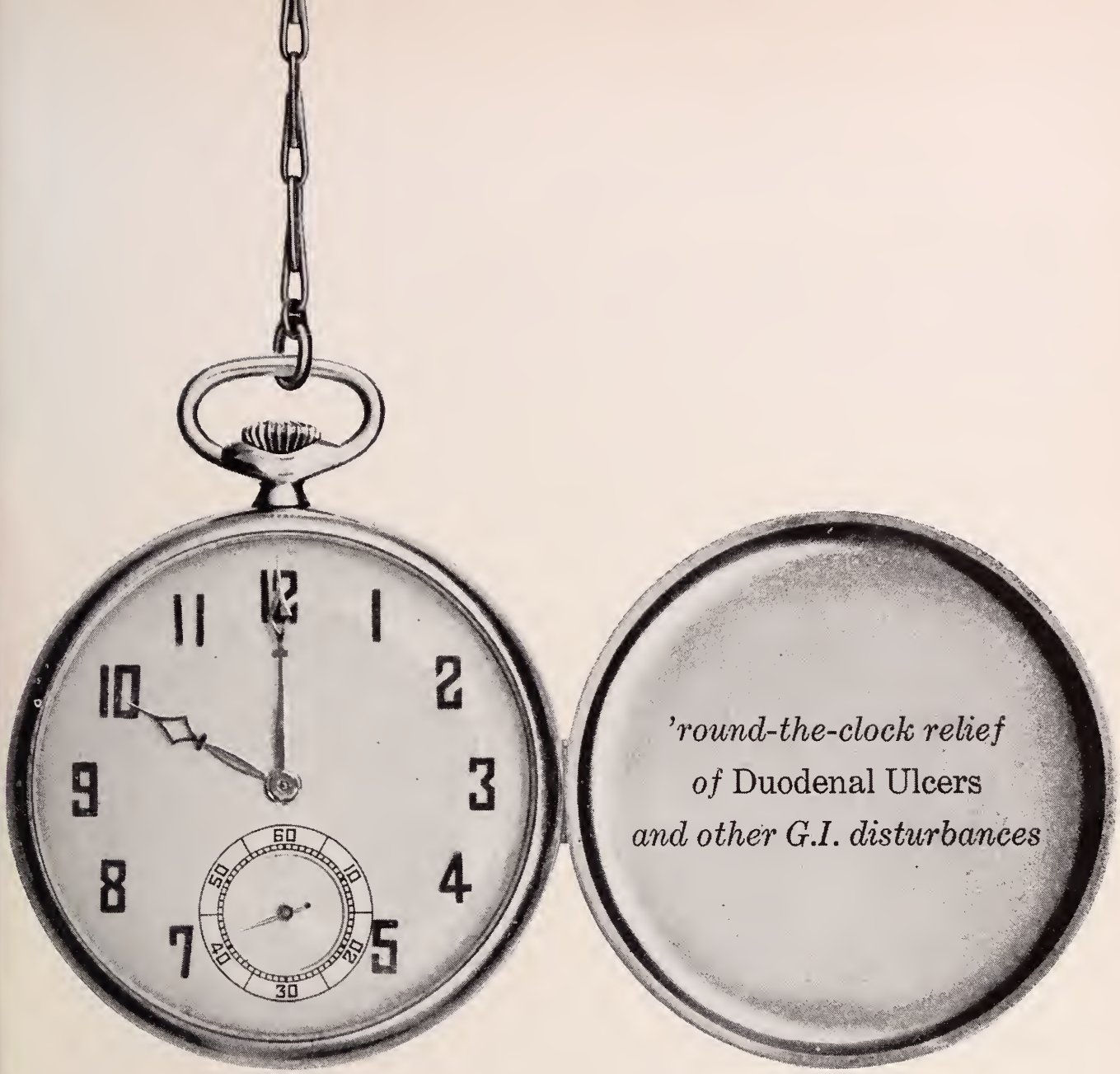
Plaquenil (brand of hydroxychloroquine) and Aralen (brand of chloroquine), trademarks reg. U.S. Pat. Off.



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daricon®

oxyphencyclimine HCl, 10 mg.

b.i.d.

"Good symptomatic responses were seen in 91 of 96 [patients] treated for periods up to one year with average doses of 10 mg. twice daily."

"[Daricon] appears to be a valuable agent . . . for day-to-day maintenance of all peptic ulcer patients."

Winkelstein, A.: Am. J. Gastroenterol. *32*:66-70 (July) 1959.

Additional information is available on request from the Medical Department, Pfizer Laboratories, Brooklyn 6, N. Y.

Pfizer *Science for the world's well-being*™

The first synthetic penicillin available for general clinical use

FOR YOUR NEXT PATIENT WHERE PENICILLIN IS INDICATEI

SYNC

PEAK BLOOD LEVELS HIGHER THAN POTASSIUM PENICILLIN V

ORAL ROUTE PROVIDES HIGHER INITIAL PEAK BLOOD LEVELS THAN INTRAMUSCULAR PENICILLIN G

IMPROVED ANTIBIOTIC ACTION FROM ISOMERIC COMPLEMENTARITY

ONSIDER THESE 6 IMPORTANT THERAPEUTIC ATTRIBUTES OF

LLIN™

potassium phenethicillin (POTASSIUM PENICILLIN-152)

ANTIBIOTIC ACTIVITY DIRECTLY-PROPORTIONAL TO ORAL DOSE

REDUCED RATE OF INACTIVATION BY STAPH PENICILLINASE

SOME STAPH STRAINS MORE SENSITIVE TO SYNCILLIN IN VITRO

BRISTOL

FOR HIGHLY EFFECTIVE THERAPY OF THE LARGE VARIETY OF INFECTIONS CAUSED BY SUSCEPTIBLE PATHOGENS...NEW

SYNC

Significance of complementary action of isomers in SYNCILLIN

The antibiotic effect of the clinically available mixture, SYNCILLIN, is greater than that of either of its two component isomers alone against many important pathogens, including some penicillin-resistant staphylococci. This phenomenon has been described as *Isomeric Complementarity*.

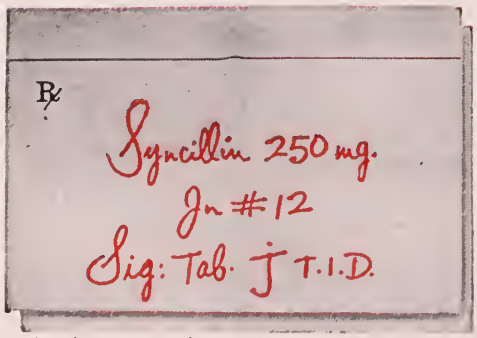
Significance of higher blood levels with SYNCILLIN

Higher blood levels may be of value with organisms of only moderate penicillin sensitivity where doubling the blood concentration may be essential for effective bactericidal action. In addition, these higher levels may be necessary where there is infection in areas with a poor blood supply. Under these circumstances a higher blood concentration may provide the increased diffusion pressure required to deliver adequate amounts to the tissue. Also, antibiotic activity of SYNCILLIN is directly proportional to oral dosage. Increasing the dosage may, therefore, enhance the drug's effectiveness in certain cases.

Efficacy of SYNCILLIN against staphylococci and other resistant organisms

Studies have shown that SYNCILLIN is effective *in vitro* against 60 to 75% of hospital "staph" strains, while penicillin G and penicillin V are now effective against only 30 to 50%.[1, 2] Therefore, if clinical judgment indicates the use of penicillin, SYNCILLIN would be expected to be the most effective. However, since some strains are still resistant to SYNCILLIN as well as to the other penicillins, cultures and sensitivity tests should be performed where indicated by clinical judgment.

There have recently been reports of decreased efficacy of penicillin in streptococcal[3] and gonococcal[4, 5] infections. The emergence of penicillin-resistant gonococci appears to be associated with an increase in the incidence of gonorrhea all over the world. When a less sensitive strain is encountered the higher blood levels produced by SYNCILLIN may be most helpful.



major therapeutic advantages accompany molecular asymmetry

LLIN™

Relation of intermittent igh blood levels SYNCILLIN o antibacterial efficacy

SYNCILLIN, like all clinically available penicillins, is bactericidal. Periodic high blood concentrations may be sufficient to permit complete eradication of sensitive pathogens. According to Eagle,[6] "Soon after penicillin attains effective concentrations, the bacteria cease multiplying; and the bacteriostatic effect persists for a number of hours after penicillin has fallen to concentrations that are wholly ineffective. . . . The therapeutic significance of this postpenicillin recovery period is enhanced by the fact that the recovering bacteria, damaged but not killed by the previous exposure to penicillin, are abnormally susceptible to the host defenses. In consequence, the bactericidal process *in vivo* continues for many hours after the drug itself has fallen to ineffective concentrations."

Reduced rate of inactivation SYNCILLIN by staph penicillinase

Bacterial resistance to penicillin has been attributed to the action of penicillin-inactivating enzymes produced by the invading organisms. SYNCILLIN is less affected by staphylococcal penicillinase than either of its component isomers. Further, SYNCILLIN is shown to be less inactivated by this enzyme than penicillin V or penicillin G. Penicillinase from *B. cereus* likewise inactivates SYNCILLIN less rapidly than penicillin V or G.

Indications: SYNCILLIN is recommended in the treatment of infections caused by pneumococci, streptococci, gonococci, corynebacteria, and penicillin-sensitive staphylococci. In addition, SYNCILLIN is effective against certain strains of staphylococci resistant to other penicillins. SYNCILLIN, like other oral penicillins, is not recommended at the present time in deep-seated or chronic infections, subacute bacterial endocarditis, meningitis, or syphilis.

Dosage: 125 mg. or 250 mg. three times daily, depending on the severity of infection. Larger doses (e.g., 500 mg. t.i.d.) may be used for more severe infections. SYNCILLIN may be administered without regard to meals. Beta hemolytic streptococcal infections should be treated with SYNCILLIN for at least ten days.

Precautions: At the present time it is not possible to draw definite conclusions regarding the incidence of allergenicity to SYNCILLIN or its cross-allergenicity with natural penicillins. *Therefore, the usual precautions for oral penicillin therapy should always be observed.* Patients with histories of asthma, hay fever, urticaria, or previous reactions to penicillin should be watched with special care. Administration of oral penicillin, in rare instances, may provoke acute anaphylaxis, particularly in penicillin-sensitive individuals.
Diarrhea has been reported occasionally following heavy dosage. If this occurs, lengthen the interval between dosages.
If superinfection occurs during therapy, appropriate measures should be taken. Since some strains of staphylococci are resistant to SYNCILLIN as well as to other penicillins, cultures and sensitivity tests should be performed where indicated by clinical judgment. As is true with all antibiotics, clinical response does not always correlate with laboratory bacterial sensitivity reports.

Supply: 125 and 250 mg. tablets, bottles of 25 and 100. 125 mg. powder for oral solution, 60 ml. vials.

References: 1. Wright, W. W.: Microbiology Report to Bristol Laboratories Inc. 2. Morigi, E. M. E.; Wheatley, W. B., and Albright, H.: Paper presented at the Seventh Antibiotic Symposium, November 4-6, 1959, Washington, D.C. 3. Editorial: New England J. Med. **261**:305 (Aug. 6) 1959. 4. King, A.: Lancet **1**:651 (March 29) 1958. 5. Epstein, E.: J.A.M.A. **169**:1055 (March 7) 1959. 6. Eagle, H. and Musselman, A. D.: J. Bact. **58**:475, 1949.

BRISTOL LABORATORIES, Division of Bristol-Myers Company, SYRACUSE, NEW YORK

Squibb Announces Chemipen

Squibb Alpha-Phenoxyethyl Penicillin Potassium

new chemically improved penicillin which provides the highest blood levels that are obtainable with oral penicillin therapy

As a pioneer and leader in penicillin therapy for more than a decade, Squibb is pleased to make Chemipen, a new chemically improved oral penicillin, available for clinical use.

With Chemipen it becomes possible as well as convenient for the physician to achieve and maintain higher blood levels—with greater speed—than those produced with comparable therapeutic doses of potassium penicillin V. In fact, Chemipen is shown to have a 2:1 superiority in producing peak blood levels over potassium penicillin V.*

Extreme solubility may contribute to the higher blood levels that are so notable with Chemipen.* Equally notable is the remarkable resistance to acid decomposition (Chemipen is stable at 37°C. at pH 2 to pH 3), which in turn makes possible the convenience of oral treatment.

And the economy for your patients will be of particular interest—Chemipen costs no more than comparable penicillin V preparations.

Dosage: Doses of 125 mg. (200,000 u.) or 250 mg. (400,000 u.), t.i.d., depending on the severity of the infection. The usual precautions must be carefully observed with Chemipen, as with all penicillins. Detailed information is available on request from the Professional Service Department.

Supply: Chemipen Tablets of 125 mg. (200,000 u.) and 250 mg. (400,000 u.), bottles of 24 tablets. Chemipen Syrup (cherry-mint flavored, nonalcoholic), 125 mg. per 5 cc., 60 cc. bottles.

*Knudsen, E. T., and Rolinson, G. N.: Lancet 2:1105 (Dec. 19) 1959.

"CHEMIPEN" IS A SQUIBB TRADEMARK.

SQUIBB

Squibb Quality—the Priceless Ingredient

Tofrānil®
brand of imipramine HCl

in depression

lights the road to recovery
in 80 per cent of cases

In the treatment of depression Tofrānil has established the remarkable record of producing remission or improvement in approximately 80 per cent of cases.[1-7]

Tofrānil is well tolerated in usage—is adaptable to either office or hospital practice—is administrable by either oral or intramuscular routes.

Tofrānil
a potent thymoleptic . . .
not a MAO inhibitor.

Does act effectively in *all* types of depression regardless of severity or chronicity.

Does not inhibit monoamine oxidase in brain or liver; produce CNS stimulation; or potentiate other drugs such as barbiturates and alcohol.

Detailed Literature Available on Request.

Tofrānil® brand of imipramine HCl: tablets of 25 mg., bottles of 100. Ampuls for intramuscular administration only, each containing 25 mg. in 2 cc. of solution, cartons of 10 and 50.

References: 1. Ayd, F. J., Jr.: Bull. School Med., Univ. Maryland *44*:29, 1959. 2. Azima, H., and Vispo, R. H.: A.M.A. Arch. Neurol. & Psychiat. *81*:658, 1959. 3. Lehmann, H. E.; Cahn, C. H., and de Verteuil, R. L.: Canad. Psychiat. A. J. *3*:155, 1958. 4. Mann, A. M. and MacPherson, A. S.: Canad. Psychiat. A. J. *4*:38, 1959. 5. Sloane, R. B.; Habib, A., and Batt, U. E.: Canad. M.A.J. *80*:540, 1959. 6. Straker, M.: Canad. M.A.J. *80*:546, 1959. 7. Strauss, H.: New York J. Med. *59*:2906, 1959.

Geigy, Ardsley, New York

Geigy

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Announcing

'ACTIFED'®

Decongestant / Antihistamine

THE POTENTIATED DECONGESTANT

provides symptomatic relief of nasal congestion and rhinorrhea of allergic or infectious origin Many patients whose symptoms are inadequately controlled by decongestants or antihistamines alone respond promptly and favorably to 'ACTIFED'.

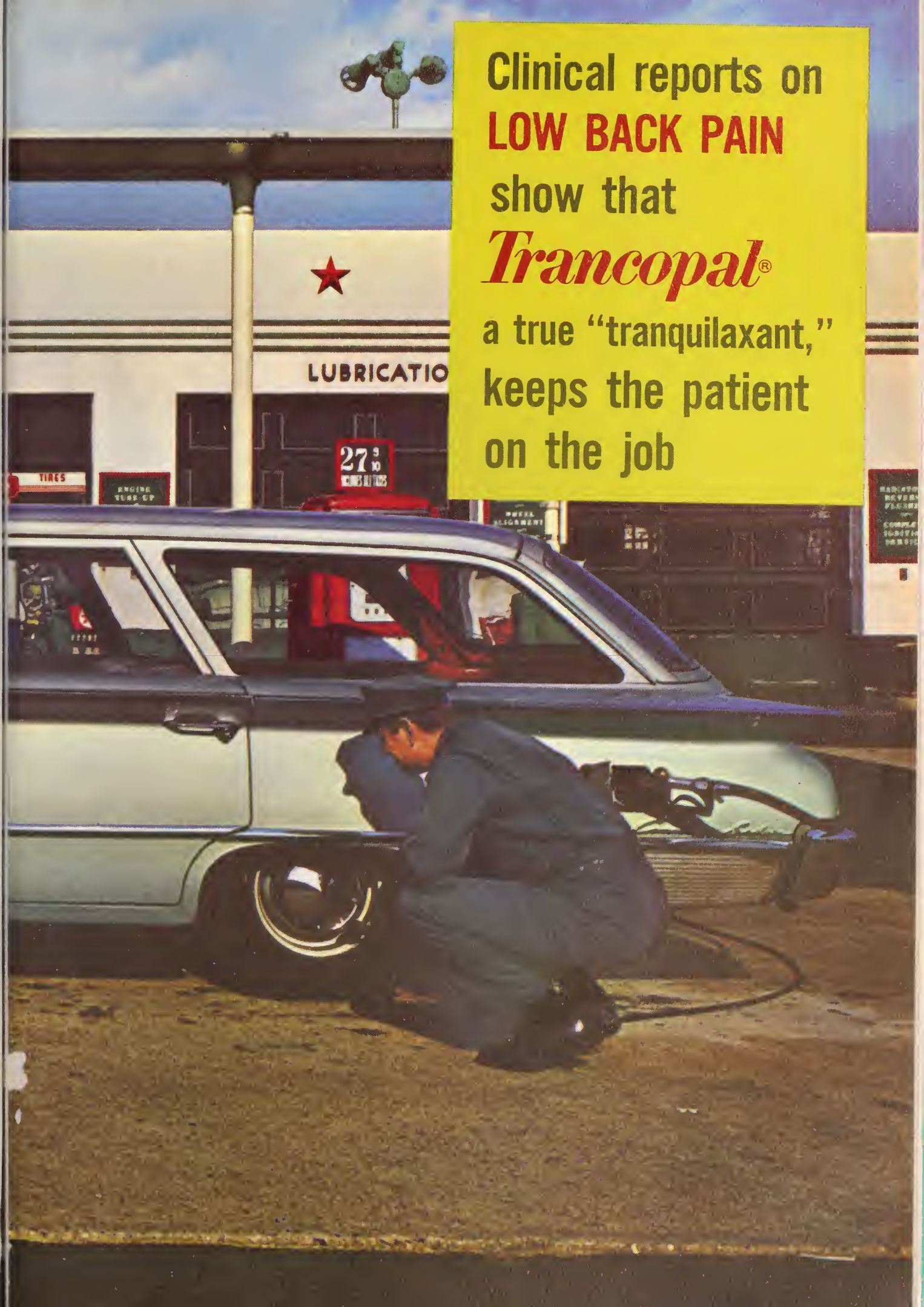
'ACTIFED' contains:	in each Tablet	in each tsp. Syrup
'Actidil'® brand Triprolidine Hydrochloride	2.5 mg.	1.25 mg.
'Sudafed'® brand Pseudoephedrine Hydrochloride	60 mg.	30 mg.

safe and effective for patients of all ages suffering from respiratory tract congestion

DOSAGE

	TABLETS	SYRUP (5 cc. tsp.)	
Adults and older children	1	2	three times daily
Children 4 months to 6 years of age	½	1	
Infants through 3 months	–	½	

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, New York


Clinical reports on
LOW BACK PAIN
show that
Trancopal®
a true "tranquilaxant,"
keeps the patient
on the job
LUBRICATIO
TIRES

A TRUE "TRANQUILAXANT"

Trancopal®

relaxes skeletal muscle spasm so the patient can continue to work

Clinical experience shows that Trancopal will enable your patients with low back pain to keep going strong. Lichtman[1] reports that 310 of his 331 patients treated with Trancopal obtained satisfactory relief. These patients were suffering from low back pain, stiff neck, postoperative muscle spasm or other skeletal muscle spasms associated with trauma, bursitis, osteoarthritis and rheumatoid arthritis. Mullin and Epifano[2] reported that Trancopal brought relief to all of 39 patients with skeletal muscle spasm. In these patients, who had suffered from trauma, bursitis, rheumatoid arthritis, osteoarthritis, and intervertebral disc syndrome, the effect of Trancopal was ". . . excellent and prompt . . ."[2] Gruenberg[3] obtained marked relief with Trancopal in 258 of 304 patients with low back pain, torticollis, arthritis and other conditions associated with skeletal muscle spasm. Moderate relief was obtained in an additional group of 28 patients. Trancopal is a true "tranquilaxant" because "It combines the properties of tranquilization and skeletal muscle relaxation with no concomitant change in normal consciousness."[4] Side effects have been few and minor — and in no case were they serious enough to warrant discontinuing the use of Trancopal.[1] "Trancopal is exceptionally safe for clinical use."[3]

relieves anxiety and tension so the patient can carry on

Trancopal is also an effective agent for patients in anxiety and tension states. According to recent clinical reports,[1,5] it calms the patients but allows them to continue their work or other activity. Indeed, Lichtman found that his patients with anxiety ". . . were in many instances able to continue their normal activities where previously they had been considerably restricted . . ."[1] He observed that Trancopal brought good to excellent relief to 114 of 120 patients in anxiety states. Ganz,[5] who noted good to excellent relief in 32 of 35 patients with globus hystericus, and in his entire series of 100 patients in anxiety or tension states, comments: "Chlormethazanone [Trancopal], by relieving the psychogenic symptoms, allows the patient to use his energies in a more productive manner in overcoming his basic problems."[5]

Relieves dysmenorrhea — Trancopal has also proved to be a useful medication in the treatment of patients with dysmenorrhea,[1,4,6] probably producing its effect ". . . by means of a combination of muscle relaxant and tranquilizing actions."[4]

Indications

Musculoskeletal disorders		Psychogenic disorders
Low back pain (lumbago)	Ankle sprain, tennis elbow	Dysmenorrhea
Neck pain (torticollis)	Osteoarthritis	Premenstrual tension
Bursitis	Rheumatoid arthritis	Anxiety and tension states
Fibrositis	Disc syndrome	Asthma
Myositis	Postoperative muscle spasm	Angina pectoris
		Alcoholism

Dosage: Adults, 100 or 200 mg. orally three or four times daily. Relief of symptoms generally occurs promptly and lasts from four to six hours.

How Supplied: Trancopal Caplets® 100 mg. (peach colored, scored) and 200 mg. (green colored, scored), bottles of 100.

ferences: 1. Lichtman, A. L.: Kentucky Acad. Gen. Pract. J. 4:28, Oct., 1958. 2. Mullin, W. G., and Epifano, Leonard: Am. Pract. & Digest Treat. :1743, Oct., 1959. 3. Gruenberg, Friedrich: Current Therap. Res. 2:1, Jan., 1960. 4. Shanaphy, J. F.: Current Therap. Res. 1:59, Oct., 1959. Ganz, S. E.: J. Indiana M. A. 52:1134, July, 1959. 6. Stough, A. R.: J. Oklahoma M. A. 52:575, Sept., 1959.

Winthrop Laboratories • New York 18, New York

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TRANCOPAL (BRAND OF CHLORMEZANONE) AND CAPLETS, TRADEMARKS REG. U. S. PAT. OFF.

clinical reports on anxiety show that

A TRUE "TRANQUILAXANT"

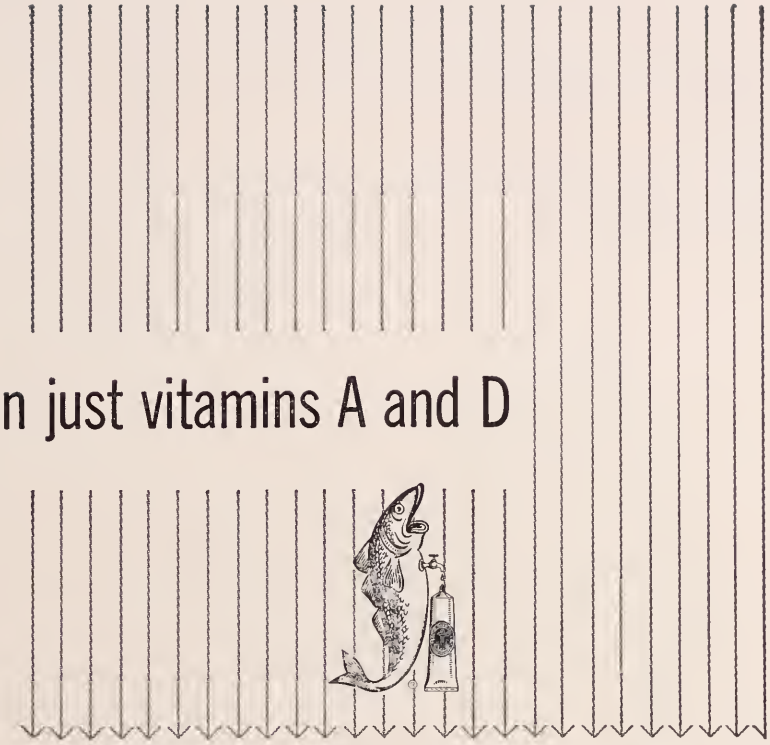
Trancopal

quiets the psyche but leaves the patient alert

"...TRANCOPAL is a most valuable drug for relieving tension, apprehension and various psychogenic states."[5]

Winthrop Laboratories

more than just vitamins A and D



DESITIN® ointment

also provides
unsaturated fatty acids as well as the vitamins A and D (of high grade Norwegian cod liver oil)—essential to skin health and integrity

and ingredients that are emollient, lubricant, gently astringent, protective, and aid tissue repair (zinc oxide, talcum, petrolatum and lanolin)

in a smooth creamy ointment so processed that one application of Desitin soothes, protects, and promotes healing for hours in . . .

diaper rash
wounds
burns
ulcers
(decubitus, diabetic, varicose)
intertrigo

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immortals of chinese mythology:

Han Hsiang-tzu

This nature-loving physician achieved immortality by falling out of a tree

TODAY..

this trail-blazing steroid is achieving lasting recognition by its unsurpassed record of accomplishment

METICORTEN

Meticorten,® brand of prednisone, 5 mg. tablets.

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You will soon receive in your mail a handmade, full-color, three-dimensional figure of this Chinese Immortal, mounted and suitable for framing.

S-348B

Schering

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Active

Ainslie, John D., Gainesville
Arnold, Gordon H., Bradenton
Beasley, Frank J., Ft. Lauderdale
Berkey, William E., Coral Gables
Blitch, Clifford G., Tallahassee
Brodsky, Leonard, Miami
Brody, Benjamin, Miami Beach
Cava, Edward E., Miami
Cooper, Thomas W., Lakeland
Ferguson, William H., Orlando
Gardner, Melvyn J., Tampa
Goulard, Alexander Jr., Ocala
Graybill, Robert E., Hollywood
Grenell, Walter B., Boca Raton
Harden, David L., Mulberry
Huckle, George T., Delray Beach
Jahn, Paul H., Winter Haven
Jordan, Steven E., Ft. Lauderdale
Klein, Robert E., Gainesville
Laurie, Robert E., Coral Gables
Longino, Grady E., Lakeland
McCoy, Donald L., Williston
Miller, George H., Jr., Winter Park
Newhall, Joseph F. P, Jr., Winter Park
Onkst, Harold R., Dunedin
Plummer, Richard W., Fort Myers
Rasmussen-Taxdal, David S., Lakeland
Regan, Peter F. III, Gainesville
Repp, Edward M., Miami
Roggenkamp, Milton W., Bradenton
Ryon, Alden B., Winter Haven
Salko, Edward W., Fort Myers
Simpson, Dazelle D., (col.), Miami
Stead, William W., Gainesville
Traggis, Demetrius G., Miami
Wachal, John H., Bunnell
Waid, Margaret E., Gainesville
Woodward, Edward R., Gainesville
Woolsey, R. Dean, Ft. Lauderdale

Associate

Ashcraft, John R., Ft. Lauderdale
Bloom, John D., Ft. Lauderdale
Braman, Robert T., Ft. Lauderdale
Bullington, Donald C., Hollywood
Clement, Baxter L., Ft. Lauderdale

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CEREBRAL
OXYGENATION

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Geroniazol TT* b.i.d.

- Each Geroniazol TT tablet contains:
  Pentylenetetrazol .....300 mg.
  Nicotinic Acid .....150 mg.
- Indications: Respiratory and circulatory stimulant for the aged and debilitated patient with symptoms of mental confusion, depression or atherosclerotic psychosis.
- Supplied: Bottles of 42 Tablets (3 weeks' treatment)

* TEMPOTROL (Time Controlled Therapy)

COLUMBUS PHARMACAL COMPANY
Columbus 16, Ohio

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Dobbrunz, Harry C., Hollywood
Fisher, Alvin, West Hollywood
Glass, Roy S., Ft. Lauderdale
Graden, Earl A., Lake Worth
Haber, Mordecai, Ft. Lauderdale
Heffner, Ralph W., Ft. Lauderdale
Henderson, Neil C., Ft. Lauderdale
Hertner, John E., Ft. Lauderdale
Hoover, Robert T., Orlando
Ifft, Robert C., W. Palm Beach
Kemp, William L., Jr., W. Palm Beach
McFall, John S. R., Ft. Lauderdale
Marchetto, Louis J., Riviera Beach
Mimnagh, William P., Jr., Pompano Beach
Nitzberg, Saul S., Hollywood
Perry, James B., Pompano Beach
Robarge, Ignace J., Hollywood
Ross, Glenn V., Deerfield Beach
Santini, Gaetano, Ft. Lauderdale
Segal, Myron I., Hollywood
Seropian, Diran M., Ft. Lauderdale
Sindell, Harlan W., Hollywood
Tienstra, Joseph E., Deerfield Beach
Van Eldik, Dick L., Lake Worth
Wiswell, Orville O., Hollywood
Wright, Jack E., W. Palm Beach

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AMUREX CAPSULES

COMPOSITION: Each capsule contains 200 mg. dl-methionine, a known amino acid.

EMPTY ONE CAPSULE — IN ONE BOTTLE — ONCE A DAY PREFERABLY WHILE WARM
IN SEVERE CASES OR OLDER BABIES PERHAPS TWO

Louis S. Goldstein Clinical Medicine 59:455 (1952) / Kass Archives of Internal Medicine Vol. 100, p. 709.

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...MALNUTRITION OR
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OUTMODED AS GODEY'S FASHIONS!

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PRENALIN-O®
PRENATAL SUPPLEMENT

1. Oyster Shell Calcium - Phosphorus Free!
2. New Form of Iron!
3. Dry Filled Capsule - Sure, Quick Absorption!
4. Economical Once-A-Day Dosage!
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6. Relieves Troublesome Leg Cramps!

EACH dry filled capsule (lavender and white) provides:

Ferrous Fumarate (Iron)	150 mg.
Deep sea oyster shell (Calcium)	600 mg.
Vitamin C	50 mg.
Vitamin A	4000 USP Units
Vitamin D	400 USP Units
Vitamin B-1	2 mg.
Vitamin B-2	2 mg.
Vitamin B-6	0.8 mg.
Vitamin B-12 (Cobalamin conc. NF)	2 mcg.
Folic Acid	0.25 mg.
Niacinamide	10 mg.
Vitamin K (Menadione)	0.25 mg.
Rutin	10 mg.
Sodium Molybdate	3 mg.
Fluorine (Calcium Fluoride)	0.25 mg.
Iodine (Potassium Iodide)	0.15 mg.

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SEVERE PAIN

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SEVERE PAIN

A.P.C. WITH DEMEROL® (30 mg.)

1 or 2 tablets three or four times daily.

Considerably more effective than A.P.C. with codeine.

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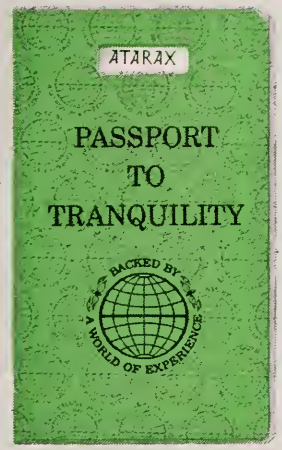
A GUIDE TO

THE REALMS OF THERAPY BEST ATTAINED WITH



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(brand of hydroxyzine)

World-wide record of effectiveness—over 200 laboratory and clinical papers from 14 countries.
Widest latitude of safety and flexibility—no serious adverse clinical reaction ever documented.
Chemically distinct among tranquilizers—not a phenothiazine or a meprobamate.
Added frontiers of usefulness—antihistaminic; mildly antiarrhythmic; does not stimulate gastric secretion.

Special Advantages	Supportive Clinical Observation	...and for additional evidence
IN CHILDREN unusually safe; tasty syrup, 10 mg. tablet	"... Atarax appeared to reduce anxiety and restlessness, improve sleep patterns and make the child more amenable to the development of new patterns of behavior...." Freedman, A. M.: Pediat. Clin. North America **5**:573 (Aug.) 1958.	Bayart, J.: Acta paediat. belg. **10**:164, 1956. Ayd, F. J., Jr.: California Med. **87**:75 (Aug.) 1957. Nathan, L. A., and Andelman, M. B.: Illinois M. J. **112**:171 (Oct.) 1957.
IN ELDERLY PATIENTS well tolerated by debilitated patients	"... seems to be the agent of choice in patients suffering from removal disorientation, confusion, conversion hysteria and other psychoneurotic conditions occurring in old age." Smigel, J. O., et al.: J. Am. Geriatrics Soc. **7**:61 (Jan.) 1959.	Settel, E.: Am. Pract. & Digest Treat. **8**:1584 (Oct.) 1957. Negri, F.: Minerva med. **48**:607 (Feb. 21) 1957. Shalowitz, M.: Geriatrics **11**:312 (July) 1956.
IN ALLERGIC PATIENTS useful adjunctive therapy for asthma and dermatosis; particularly effective in urticaria	"All [asthmatic] patients reported greater calmness and were able to rest and sleep better... and led a more normal life.... In chronic and acute urticaria, however, hydroxyzine was effective as the sole medicament." Santos, I. M., and Unger, L.: Presented at 14th Annual Congress, American College of Allergists, Atlantic City, New Jersey, April 23-25, 1958.	Eisenberg, B. C.: J.A.M.A. **169**:14 (Jan. 3) 1959. Coirault, R., et al.: Presse méd. **64**:2239 (Dec. 26) 1956. Robinson, H. M., Jr., et al.: South. M. J. **50**:1282 (Oct.) 1957.
IN HYPEREMOTIVE ADULTS does not impair mental acuity	"... especially well-suited for ambulatory neurotics who must work, drive a car, or operate machinery." Ayd, F. J., Jr.: New York J. Med. **57**:1742 (May 15) 1957.	Garber, R. C., Jr.: J. Florida M. A. **45**:549 (Nov.) 1958. Menger, H. C.: New York J. Med. **58**:1684 (May 15) 1958. Farah, L.: Internat. Rec. Med. **169**:379 (June) 1956.

SUPPLIED: Tablets, 10 mg., 25 mg., 100 mg.; bottles of 100. Syrup (10 mg. per tsp.), pint bottles. Parenteral Solution: 25 mg./cc. in 10 cc. multiple-dose vials; 50 mg./cc. in 2 cc. ampules.

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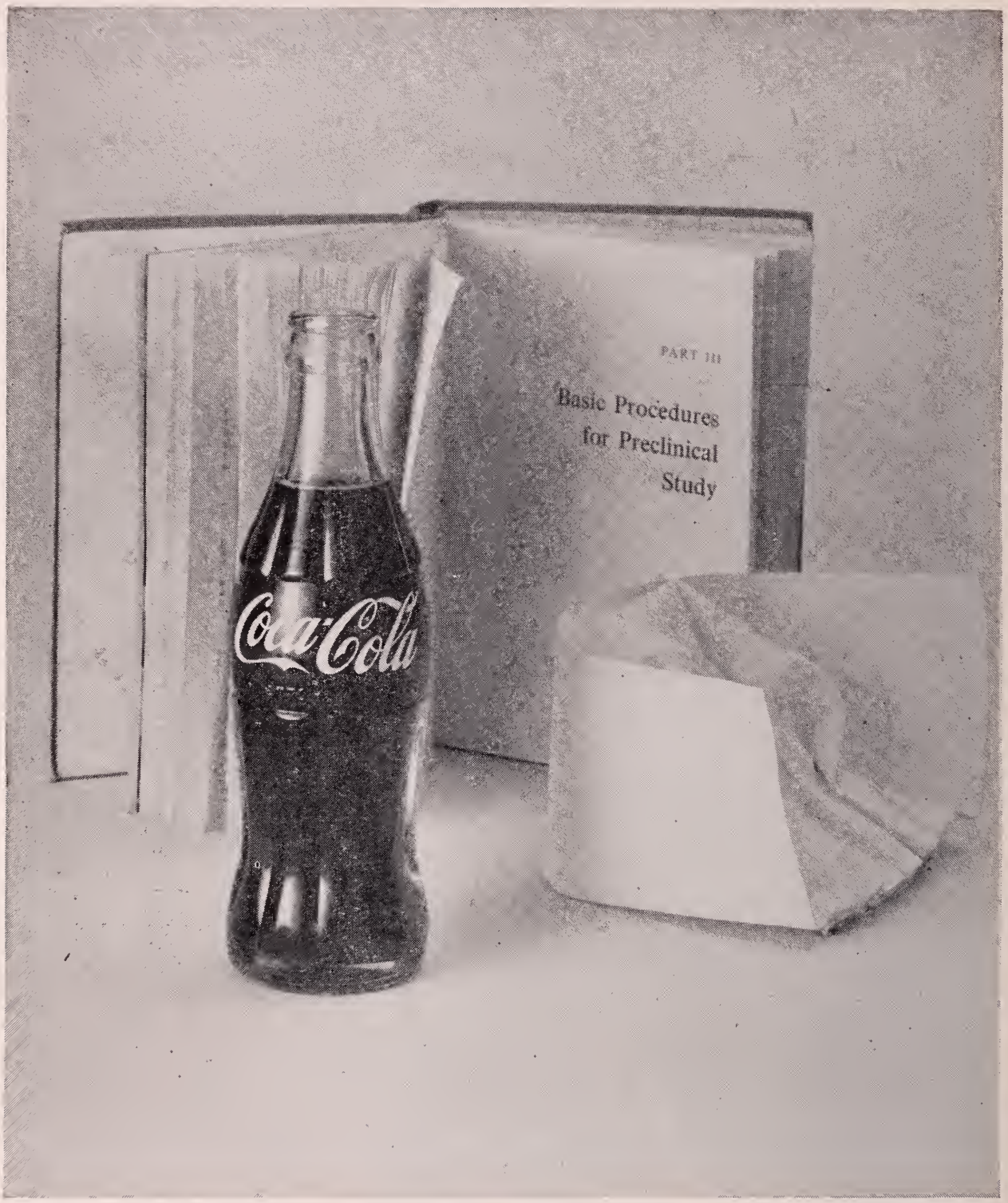
Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being



When too many tasks seem to crowd the unyielding hours, a welcome "pause that refreshes" with ice-cold Coca-Cola often puts things into manageable order.

REFRESHES YOU BEST

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relieves both stiffness and pain with safety... sustained effect

In 100 consecutive patients with the low back syndrome, Kestler[1] reported that particularly gratifying was the ability of Soma "to relax muscular spasm, relieve pain, and restore normal movement, thus speeding recovery in a large majority of the patients."

RESULTS WITH SOMA IN THE LOW BACK SYNDROME*

*Investigators' reports to the Medical Department, Wallace Laboratories. (Total of 278 cases)

NOTABLE SAFETY—extremely low toxicity; no known contraindications; side effects are rare; drowsiness may occur, usually at higher dosage

RAPID ACTION—starts to act quickly **SUSTAINED EFFECT**—relief lasts up to 6 hours

EASY TO USE—usual adult dosage is one 350 mg. tablet 3 times daily and at bedtime

SUPPLIED—as white, coated, 350 mg. tablets, bottles of 50; also available for pediatric use: 250 mg., orange capsules, bottles of 50

1. Kestler, O.: In The Pharmacology and Clinical Usefulness of Carisoprodol, Wayne State University Press, Detroit, 1959. 2. Berger, F. M.; Kletzkin, M.; Ludwig, B. J.; Margolin, S., and Powell, L. S.: J. Pharm. Exp. Ther. *127*:66 (Sept.) 1959. 3. Spears, C. E. and Phelps, W. M.: Arch. Pediat. *76*:287 (July) 1959. 4. Phelps, W. M.: Arch. Pediat. *76*:243 (June) 1959. 5. Friedman, A. P.; Frankel, K., and Fransway, R. L.: Papers presented at Scientific Meeting, New York State Society of Industrial Medicine, Inc., New York, Sept. 30, 1959. 6. Kuge, T.: Unpublished reports. 7. Ostrowski, J. P.: Orthopedics *2*:7 (Jan.) 1960.

Literature and samples on request

Also available on request: The Pharmacology and Clinical Usefulness of Carisoprodol, Wayne State University Press, Detroit, 1959. (185 pages)

SOMA™

(carisoprodol Wallace)

Wallace Laboratories, New Brunswick, New Jersey

Q. *When you want to reduce serum cholesterol and maintain it at a low level, is medication realistic than dietary modifications?*

A. *Maintenance of lowered cholesterol concentration in the blood is a life-long problem. It is usually preferable, therefore, to try to obtain the desired results through simple dietary modification. This spares the patient added expense and permits him meals he will relish.*

The modification is based on a diet to maintain optimum weight plus a judicious substitution of the poly-unsaturated oils for the saturated fats. One very simple part of the change is to cook the selected foods with poly-unsaturated Wesson. In the prescribed diet, this switch in type of fat will help to lower blood serum cholesterol and help maintain it at low levels. The use of Wesson permits a diet planned around many favorite and popular foods. Thus the patient finds it a pleasant, easy matter to adhere to the prescribed course.

Where a vegetable (salad) oil is medically recommended for a cholesterol depressant regimen, Wesson is unsurpassed by any readily available brand.

Uniformity you can depend on. Wesson has a poly-unsaturated content better than 50% . Only the lightest cottonseed oils of highest iodine number are selected for Wesson. No significant variations are permitted in the 22 exacting specifications required before bottling.

Wesson satisfies the most exacting appetite
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majority of housewives prefer Wesson partic
the criteria of odor, flavor (blandness) and li
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REE *Wesson recipes, available in quantity for your patients, show how to epare meats, seafoods, vegetables, salads and desserts with poly-unsaturated oil. Request quantity needed from Wesson People, Dept. N., 210 Baronne St., New Orleans 12, La.*

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Wesson is 100% cottonseed oil . . . winterized and of selected quality

Linoleic acid glycerides (poly-unsaturated)	50-55%
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Total unsaturated	70-75%
Palmitic, steoric and myristic glycerides (saturated)	25-30%
Phytosterol (predominantly beta sitosterol)	0.3-0.5%
Total tocopherols	0.09-0.12%

Never hydrogenated—completely salt free

Each pint of Wesson contains 437-524 Int. Units of Vitamin E

Today—as before—

Only Kent offers this remarkable combination:

FINEST NATURAL TOBACCOS
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Millions of smokers have changed to Kent because of this combination. They discovered that this combination was the reason why Kent satisfies your appetite for a real good smoke.

First, finest natural tobaccos. Kent uses *only* the finest natural tobaccos—ripe, golden leaves—which, when shredded into tiny strands and carefully blended, produce a real tobacco taste.

Second, Kent's famous Micronite filter which contains a remarkable series of flavor channels. The rich taste of natural tobaccos flows through with a free and easy draw. The Kent filter is not too long, not too short, not too tight—smokers get every delicate shading of flavor of Kent's finest natural tobaccos.

Others may imitate, but none can duplicate the quality of Kent.

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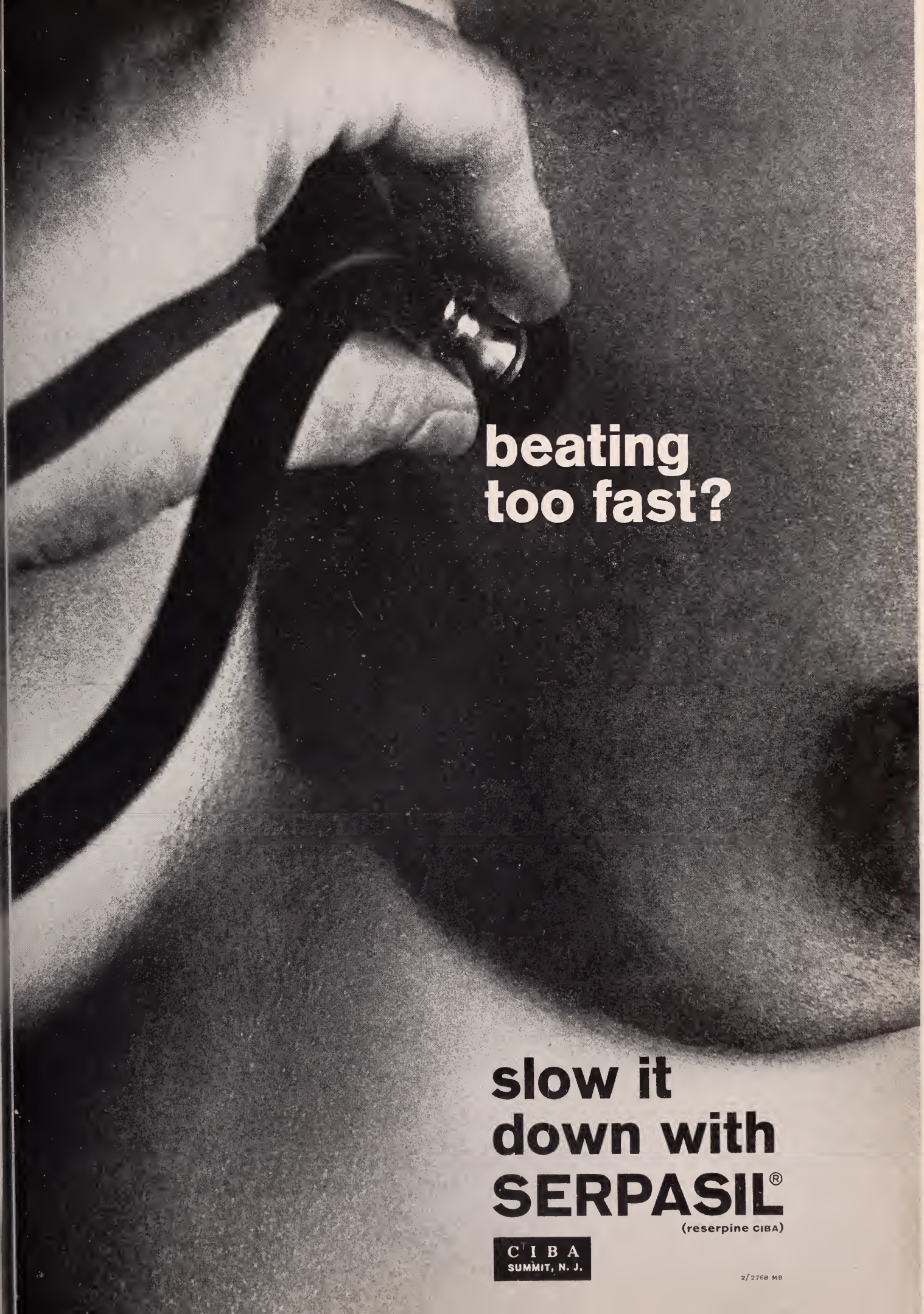
Today—as before—for good smoking taste, it makes good sense to smoke Kent, because Kent satisfies your appetite for a real good smoke.

A Product of P. Lorillard Company—First with the finest cigarettes—through Lorillard Research!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slow it
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control the tension—treat the trauma

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meprobamate with PATHILON® tridihexethyl chloride Lederle

greater flexibility in the control of tension, hypermotility and excessive secretion in gastrointestinal dysfunctions

PATHIBAMATE combines two highly effective and well-tolerated therapeutic agents:

mebrobamate (400 mg. or 200 mg.) widely accepted tranquilizer and . . .

PATHILON (25 mg.)—anticholinergic noted for its peripheral, atropine-like action, with few side effects.

The clinical advantages of PATHIBAMATE have been confirmed by nearly two years' experience in the treatment of duodenal ulcer; gastric ulcer; intestinal colic; spastic and irritable colon; ileitis; esophageal spasm; anxiety neurosis with gastrointestinal symptoms and gastric hypermotility.

Two dosage strengths—PATHIBAMATE-400 and PATHIBAMATE-200 facilitate individualization of treatment in respect to both the degree of tension and associated G.I. sequelae, as well as the response of different patients to the component drugs.

Supplied: **PATHIBAMATE-400**—Each tablet (yellow, 1/2-scored) contains meprobamate, 400 mg.; PATHILON tridihexethyl chloride, 25 mg.

PATHIBAMATE-200—Each tablet (yellow, coated) contains meprobamate, 200 mg.; PATHILON tridihexethyl chloride, 25 mg.

Administration and Dosage: **PATHIBAMATE-400**—1 tablet three times a day at mealtime and 2 tablets at bedtime.

PATHIBAMATE-200—1 or 2 tablets three times a day at mealtime and 2 tablets at bedtime.

Adjust to patient response.

Contraindications: glaucoma; pyloric obstruction, and obstruction of the urinary bladder neck.

Lederle

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

after milk and rest, why Donnalate?

Once you've prescribed milk and rest for a peptic ulcer patient, Donnalate may be the best means for fulfilling his therapeutic regimen. This is because Donnalate combines several recognized agents which effectively complement each other and help promote your basic plan for therapy. A single tablet also simplifies medicine-taking.

in Donnalate: Dihydroxyaluminum aminoacetate affords more consistent neutralization than can diet alone. • Phenobarbital improves the possibility of your patient's resting as you told him to. • Belladonna alkaloids reduce GI spasm and gastric secretion. And by decreasing gastric peristalsis, they enable the antacid to remain in the stomach longer.

Each Donnalate tablet equals one Robalate® tablet plus one-half Donnatal® tablet: Dihydroxyaluminum aminoacetate, N. F., 0.5 Gm.; Phenobarbital (1/8 gr.), 8.1 mg.; Hyoscyamine sulfate, 0.0519 mg.; Atropine sulfate, 0.0097 mg.; Hyoscine hydrobromide, 0.0033 mg.

Donnalate®

A. H. Robins Co. INC.
RICHMOND 20, VIRGINIA

reaches all nasal and paranasal membranes *systemically*[1]

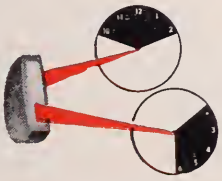
Pharmacologically balanced formula for prompt symptomatic relief

- in nasal and paranasal congestion
- in sinusitis and postnasal drip
- in allergic reactions of the upper respiratory tract

Triaminic[2,3] is safer and more effective than topical medication

- transported systemically to *all* respiratory membranes
- provides longer-lasting relief
- presents no problem of rebound congestion
- avoids "nose drop addiction"

Relief is prompt and prolonged because of this special timed-release action:



first — the outer layer dissolves within minutes to produce 3 to 4 hours of relief

then — the core disintegrates to give 3 to 4 *more* hours of relief

Each Triaminic timed-release Tablet provides:
Phenylpropanolamine HCl.....50 mg.
Pheniramine maleate.....25 mg.
Pyrilamine maleate.....25 mg.

Dosage: 1 tablet in the morning, midafternoon and at bedtime. In postnasal drip, 1 tablet at bedtime is usually sufficient.

Each timed-release Triaminic Juvelet® provides: ½ the formulation of the Triaminic Tablet.

Dosage: 1 Juvelet in the morning, midafternoon and at bedtime.

Each tsp. (5 ml.) of Triaminic Syrup provides: ¼ the formulation of the Triaminic Tablet.

Dosage (to be administered every 3 or 4 hours): *Adults* — 1 or 2 tsp.; *Children 6 to 12* — 1 tsp.; *Children 1 to 6* — ½ tsp.; *Children under 1* — ¼ tsp.

1. Fabricant, N. D.: E.E.N.T. Monthly *37*:460 (July) 1958.
2. Lhotka, F. M.: Illinois M. J.: *112*:259 (Dec.) 1957.
3. Farmer, D. F.: Clin. Med. *5*:1183 (Sept.) 1958.

the leading oral nasal decongestant...

Triaminic®

timed-release tablets and juvelets
also non-alcoholic, fruit-flavored syrup

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When you buy an electrocardiograph*, the manufacturer has two obligations to you:

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As a Sanborn owner, you receive this continuing service in many forms, through nearby Branch Offices, Service Agencies and Resident Representatives in 46 cities: "emergency" calls when required, and prompt response to routine requests for supplies and accessories . . . ECG Study Courses (by correspondence); the bi-monthly Sanborn Technical Bulletin; comprehensive instrument Instruction Manuals . . . and a Question and Answer Service for any problems in the use of Sanborn instruments.

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depth

in topical anesthesia

New 4% Xylocaine® HCl applied topically to the larynx, pharynx, and trachea, gives fast, intense and profound anesthesia for endoscopic procedures. Whenever effective anesthesia of the mucosa of the eye, ear, nose and throat is required, topical Xylocaine HCl 4% offers all these advantages ▪ fast anesthetic action ▪ intense depth of anesthesia—not just surface analgesia ▪ effectiveness in small volumes—average 4 cc. ▪ patients experience no pain ▪ relatively nonirritating and nonsensitizing ▪ side effects are extremely rare. In ophthalmology, Xylocaine HCl 4% used both topically and by retrobulbar injection, provides fast, deep, and enduring anesthesia for a wide variety of major as well as minor surgical techniques. Xylocaine® HCl (brand of lidocaine*)

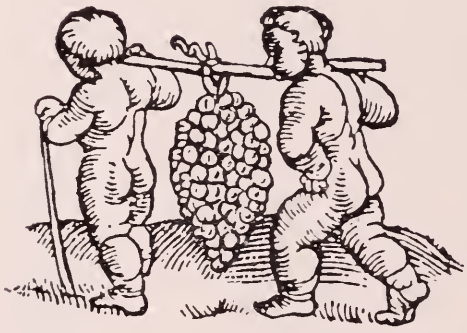
Administration and Dosage: For topical anesthesia, Xylocaine HCl 4% may be applied as a spray or with cotton applicators or packs, and by instillation into a cavity. The suggested volume ranges, for adults, from one to five cc. (40-200 mg.). For children, debilitated and aged patients, dosages should be proportionately reduced. Prior to removal of foreign bodies from the eye, examination of corneal lacerations, cauterization of corneal ulcers, and other surgical and diagnostic procedures, 2 to 3 drops of Xylocaine HCl 4% will usually produce adequate anesthesia.

How Supplied: For Transtracheal and Retrobulbar Injection and Topical Application—Sterile aqueous solution dispensed in 5 cc. color-break ampules, packed 10 ampules to a carton. For Topical Use Only—Aqueous solution in 50 cc. screw cap bottles, individually cartoned.

*U.S. Patent No. 2,441,498 Made in U.S.A

Astra Pharmaceutical Products, Inc., Worcester 6, Mass.

why wine in digestive disorders?



Although the effects of wine on the digestive system have been discussed for centuries, it has been only in recent years that many of its physiological attributes have been determined.

WINE AND THE SALIVARY GLANDS—The increase in salivary flow following a moderate intake of wine is apparent almost immediately,[1] such increase being attributed to direct sensitization of secretory nerve endings.[2]

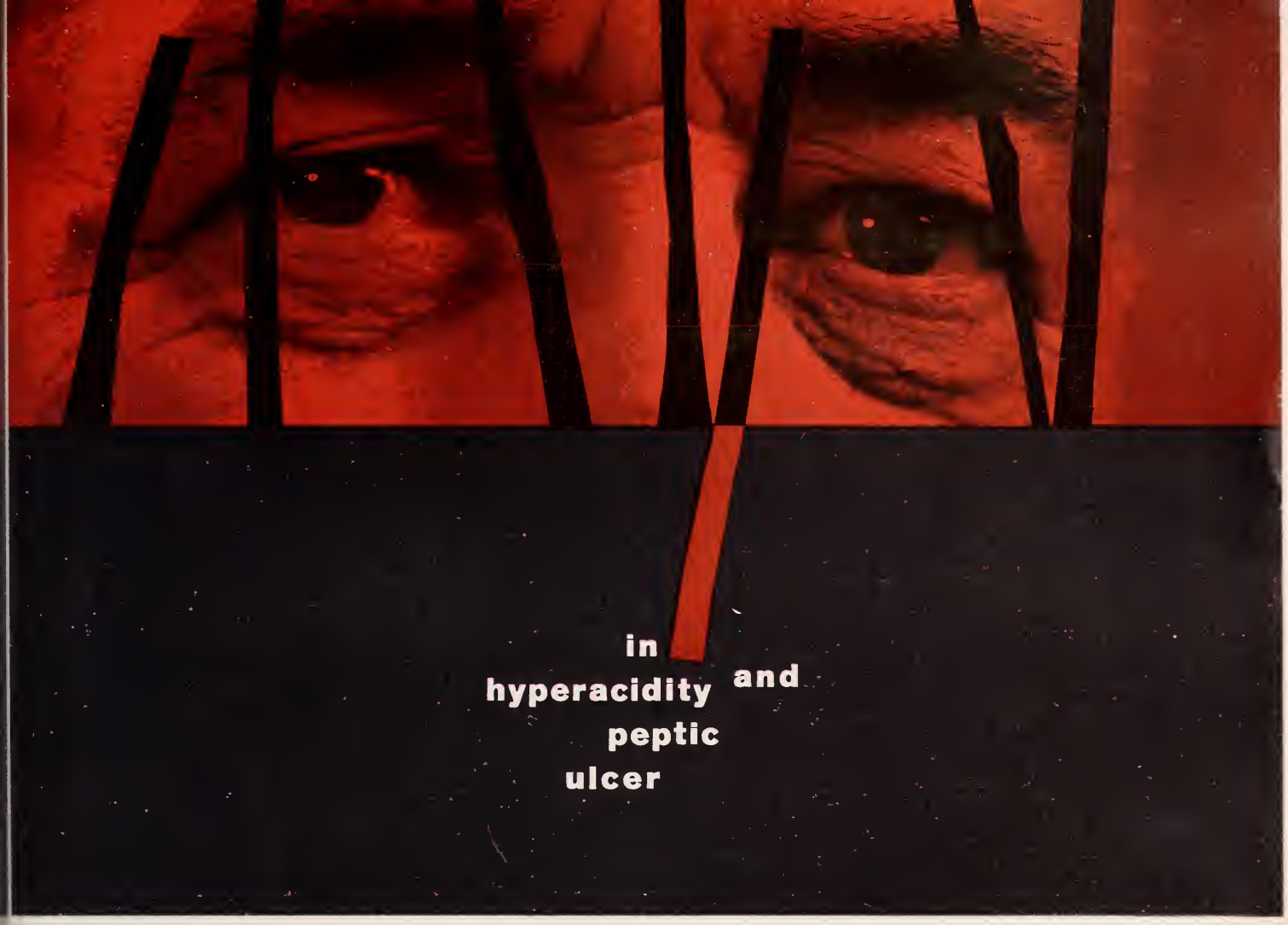
WINE AND GASTRIC SECRETION—With a pH averaging 3.2, wine resembles gastric juice more closely than does any other natural beverage. Its tannins, organic acids and salts of these acids serve as buffering agents to maintain this pH. Relatively low in content of alcohol, table wine has been found to stimulate gastric secretion and induce production of gastric juice high in hydrochloric acid, sodium chloride, rennin and pepsin.[3]

WINE AND THE DIGESTIVE TRACT—With its low concentration of alcohol, wine in moderate consumption has been found to induce a marked increase in biliary flow.[4] This, together with increased function of pancreatic enzymes, may thus encourage better digestion of fatty foods.

THEREFORE—IN THE TREATMENT OF DIGESTIVE DISORDERS—Wine is being widely recommended in the treatment of anorexia, hypochlorhydria without gastritis, mucous colitis, spastic constipation and diarrhea, and in digestive disorders stemming from emotional tension and anxiety.

These and other modern ℞ uses for wine are discussed in the brochure "Uses of Wine in Medical Practice." For your free copy write—Wine Advisory Board, 717 Market Street, San Francisco 3, California.

1. Winsor, A. L. and Strangin, E. I.: J. Exper. Psychol. 16:589 (1933).
2. Beazell, J. M., and Ivy, A. C.: Quart. J. Studies on Alc. 1:45 (1940).
3. Faroy, G., and Weissenbach, R. J.: Hôpital 25:306 (1937).
4. Okada, S.: J. Physiol. 49:457 (1915).



as reactive in tablet form . . .

ALGLYN®

Dihydroxy aluminum aminoacetate

The superiority of Alglyn (dihydroxy aluminum aminoacetate) as an antacid over ordinary aluminum preparations is quite pronounced. Not only do Alglyn Tablets act as rapidly as aluminum hydroxide gels and magmas, but they maintain a much more effective pH for a longer time (see chart).

Furthermore, Alglyn Tablets are decidedly superior when antacid-belladonna therapy is indicated. Ordinary aluminum preparations may actually *ad*sorb as much as 80% of the spasmolytic drug, as compared to only 7% for Alglyn Tablets. In addition, Alglyn contains no sodium and less aluminum.

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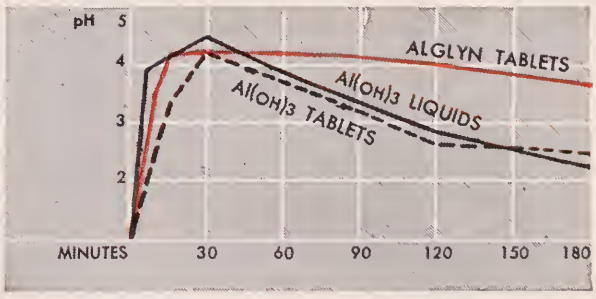

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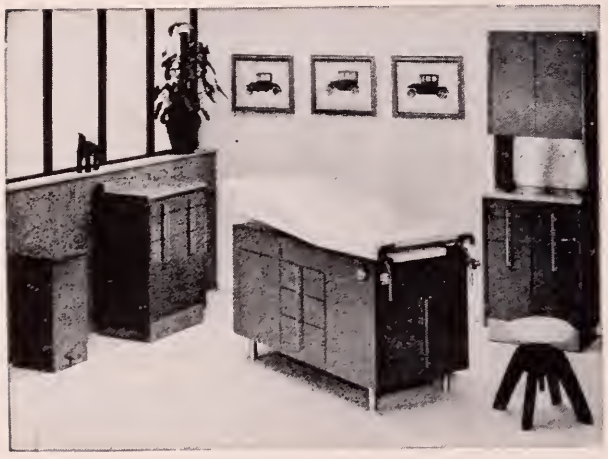

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OBITUARIES

Arthur Derby Draper

Dr. Arthur Derby Draper of Tampa died in a local hospital on Sept. 26, 1959. He was 85 years of age.

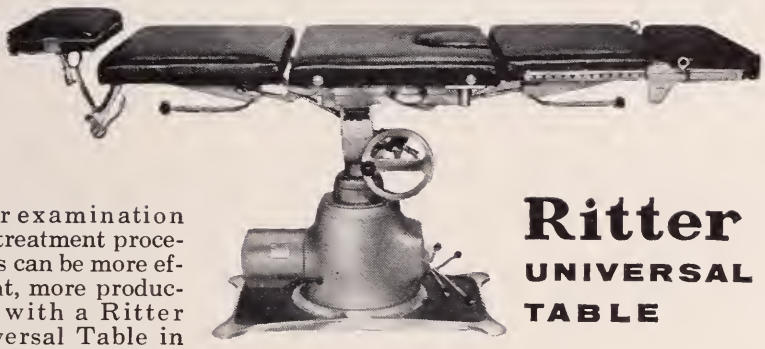
Born in Boston, Mass., on Aug. 30, 1874, Dr. Draper was the son of Fannie Victoria Jones Draper and Dr. Frank Winthrop Draper, a practicing physician of Boston and Professor of Legal Medicine at Harvard University, being the author of the text book used in that subject.

Dr. Draper received his medical training at Harvard Medical School, where he was awarded the degree of Doctor of Medicine in 1903. He was a member of the Boylston Society and served on the staff of the Boston City Hospital. He was also a member of the staff of the the Long Island Hospital and Assistant Superintendent of Isolation Hospital in New Jersey.

In 1910, after having practiced in Waltham, Mass., for several years, he moved to the Isle of Pines, where for years he was the only American physician on the island to be qualified by Havana University. In 1912, he was married to Louise Matschke, and three children were born to them on the Isle of Pines. Seeking adequate schooling for their children, they returned to the United States in 1923 and located in Tampa, where the youngest son, Arthur Jr., was born. Dr. Draper engaged in the general practice of medicine in Tampa for 33 years, retiring in December 1956. Locally, he served on the staff of St. Joseph's Hospital and the Tampa General Hospital. For many years he was a member, senior warden and vestryman of St. Andrew's Episcopal Church.

Dr. Draper was a member of the Hillsborough County Medical Association, and for 30 years had been a member of the Florida Medical Association. He also held membership in the American Medical Association and the Southern Medical Association.

Surviving are the widow, Mrs. Louise Draper, of Tampa; a daughter, Mrs. Ruth D. Hoover, of Havana; and two sons, Major Frank W. Draper, of Hickam Air Force Base, Hawaii, and Dr. Arthur D. Draper Jr., of MacDill Air Force Base, Tampa; and four grandchildren.



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Preferably, antibiotic therapy should be based on pretreatment culture of the offending pathogen, but in bacterial pneumonia the problem may well be too pressing to permit the required delay of 24 to 48 hours. A differential diagnosis among bacterial pneumonias, based on such clinical grounds as speed of onset, sepsis and pain may guide the choice of antibiotic for initiation of therapy.

Should clinical judgment dictate that antibiotic therapy be started immediately, at the same time a sputum sample or a subglottic swab can be sent to the laboratory for culture and sensitivity studies. If the response to the first antimicrobial agent proves unsatisfactory, a reasonable basis for changing therapy will then be at hand.

Choosing the Antibiotic

Since therapy must be started at once for bacterial pneumonia, it is advisable to choose a broad-spectrum antibiotic that quickly produces high levels of active agent (e.g., tetracycline phosphate complex, TETREX). Such an antibiotic probably has the best chance of controlling the pathogen, whether it be gram-negative or gram-positive. And if the laboratory report shows that the invading organism is much less sensitive to tetracycline than to other agents, the patient can then be changed to an appropriate antibiotic. If the difference in sensitivity is slight, then the possibility of side effects, sensitization, and toxicity should be evaluated before changing therapy to another antibiotic.

The greatest number of bacterial pneumonias are caused by pneumococci, which respond very well to penicillin, tetracycline, and chloramphenicol. Also, these antibiotics are usually effective against the other gram-positive coccal pneumonias. But penicillin is ineffective against the viral pneumonias and the gram-negative *Hemophilus influenzae* and *Klebsiella pneumoniae*. Although *K. pneumoniae* causes only about 1 to 2 per cent of pneumonia cases on the average,[1] these are apt to be acute and fulminating (Friedländer's pneumonia), with a high mortality rate if not effectively treated. Since pneumococcal pneumonia may be difficult to distinguish clinically from Friedländer's, except by gram-stained sputum smear, it may be wiser to start treatment with an agent also effective against Klebsiella.

Penicillin, however, in addition to having a limited spectrum, also causes many minor and some serious sensitivity reactions. In a recent survey[2] it was found that penicillin produced severe skin reaction. But most important was the observation that anaphylactic shock, with a fatality rate of about 9 per cent, was the most frequent serious reaction. Such severe reactions are almost always associated with parenteral administration.

Tetracycline is also clinically effective in primary atypical pneumonia.[3]

The tetracyclines (e.g., TETREX) have the advantage of a broad range of antimicrobial activity and low toxicity. And in addition, the physician does not have to trouble himself or his patients with repeated blood studies when he prescribes TETREX. Minor reactions such as gastric upsets or mild skin rashes occur occasionally. The most serious side effects are staphylococcal and monilial overgrowth, but these are rare and can be adequately controlled.

No one would deny that appropriate antibiotic therapy has greatly reduced morbidity and saved many lives of patients with bacterial pneumonia. Nevertheless, general supportive measures in the care of patients remain important even today. Especially in the desperately ill patient, antibiotics are not considered as substitutes for the individual evaluation, clinical observation and judgment of the physician.

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a Some strains are not susceptible.

b Table adapted from Goodman, L. S., and Gilman, A.: The Pharmaceutical Basis of Therapeutics. 2nd edition, New York, The Macmillan Co., 1956, pp. 1322-1323.

References: 1. Wood, W. E., Jr.: In: A Textbook of Medicine. Edited by Cecil, R. L., and Loeb, R. F., 9th edition, Philadelphia, W. B. Saunders Co., 1955, p. 145. 2. Welch, H.; Lewis, C. H.; Weinstein, H. I., and Boeckman, B. B.: Severe reactions to antibiotics. A nationwide survey. Antibiotic Med. & Clin. Ther. 4:800 (Dec.) 1957. 3. Keefer, C. S.: The choice of an anti-infective agent. In: Drugs of Choice, 1958-1959. Edited by Walter Modell, St. Louis, The C. V. Mosby Co., 1958, p. 135.

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1. Lippmann, O.: Arch. Ophth. **57**:339, March 1957.
2. Gordon, D.M.: Am. J. Ophth. **46**:740, November 1958.

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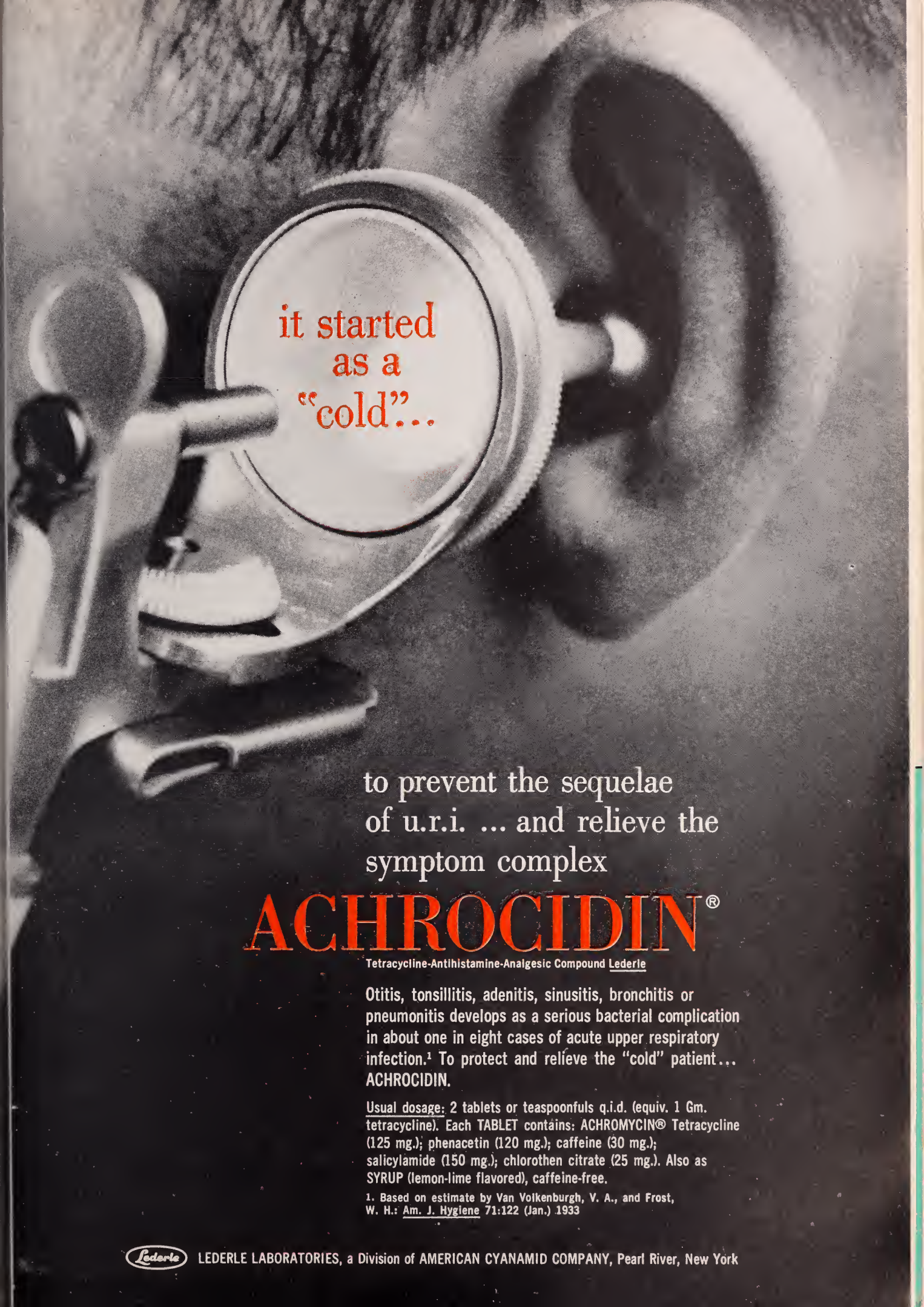

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1. Based on estimate by Van Volkenburgh, V. A., and Frost, W. H.: Am. J. Hygiene 71:122 (Jan.) 1933

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BOOKS RECEIVED

Preventive Medicine. *Principles of Prevention in the Occurrence and Progression of Disease.* Edited by Herman E. Hilleboe, M.D., and Granville W. Larimore, M.D. Pp. 731. Illus. 59. Price, $12.00. Philadelphia, W. B. Saunders Company, 1959.

This book sets forth a new way to look at preventive medicine for medical students, general practitioners, specialists and professional workers in official and voluntary health agencies. As its main theme the book distinguishes between two clearly defined areas: (1) the prevention of occurrence of disease and disability, and (2) the prevention of their progression after contraction. The editors stress the role of the individual practicing physician in preventive medicine and emphasize throwing up barriers to disease before its onset. They are joined by 29 other staff members of the New York State Health Department in presenting material from lectures, seminars and articles by these experts in preventive medicine and public health. Their training and experience cover a broad spectrum of medical service, teaching and research, and their purpose is to outline a practical guide to physicians who are willing to incorporate preventive medicine as an integral part of their day to day practice in the office, in the hospital, in the home and in the community in which they live. There are chapters on control of environmental factors, prophylactic measures against disease, elimination of predisease conditions, prevention of progression of disease, rehabilitation, alcoholism, and narcotic addiction. Supporting services such as patient education, public health nursing, and the role of the hospital in disease prevention are discussed as they apply to the over-all picture of preventive medicine. To the general practitioner, school and public health physicians and medical students this book offers a new, sensible, and usable approach to the prevention and control of disease.

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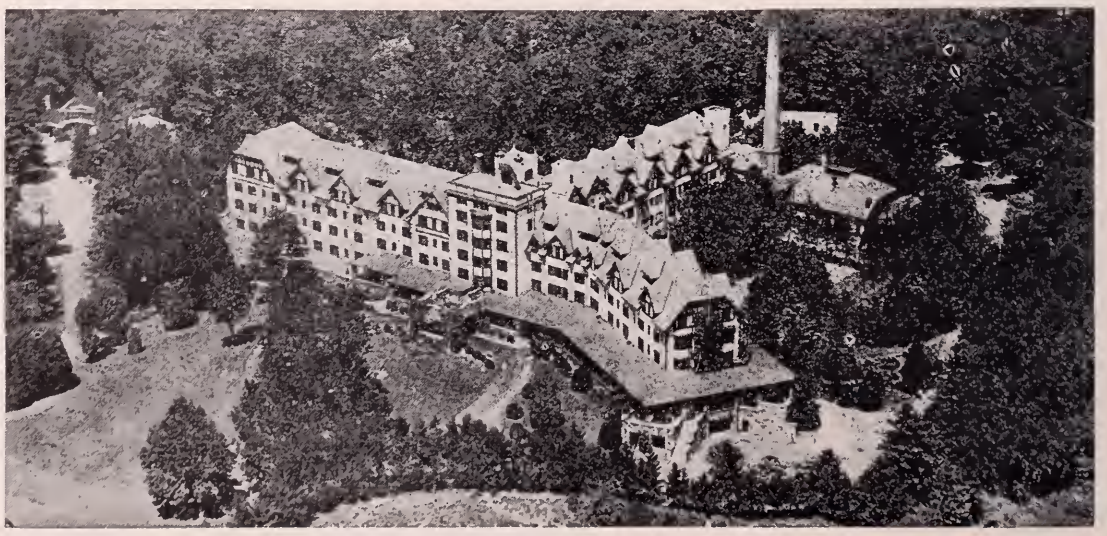

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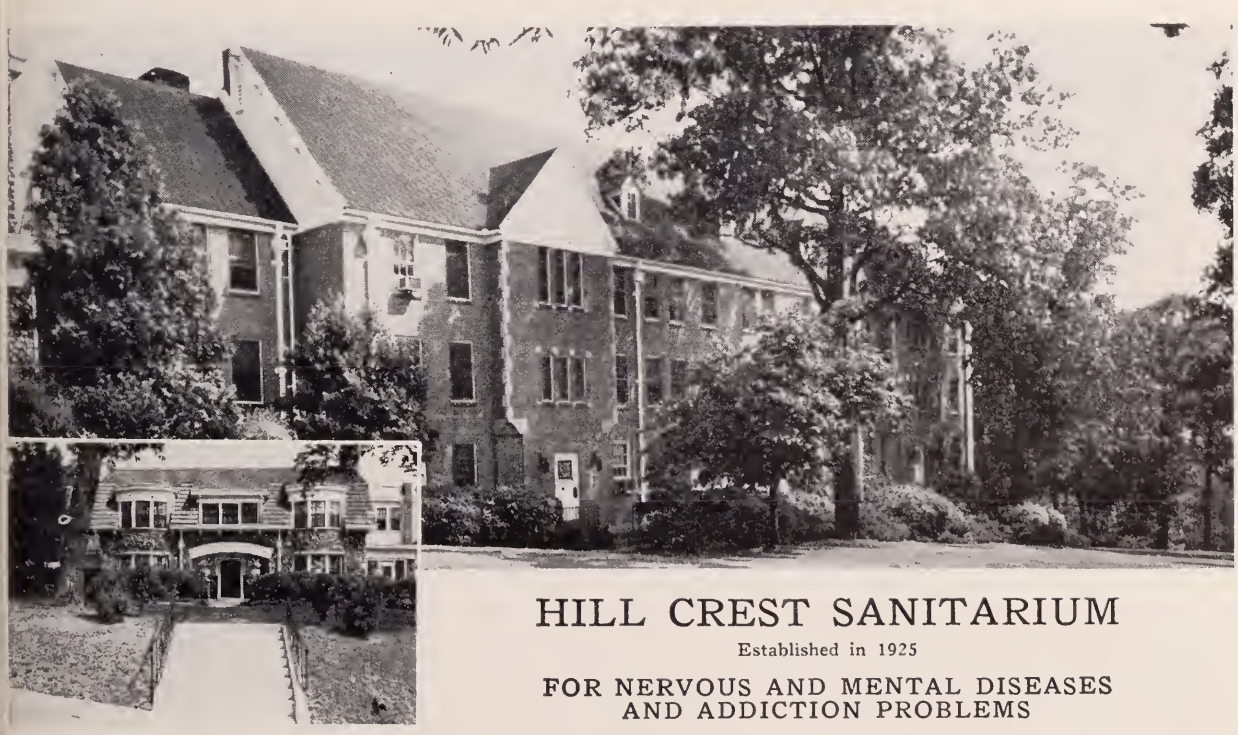

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rican Medical Association	Louis M. Orr, Orlando	F. J. L. Blasingame, Chicago	Miami Beach, June 13-17, '60
M.A. Clinical Session			Wash., D. C., Nov. 28-Dec. 2, '60
hern Medical Association	Milford O. Rouse, Dallas, Texas	Merle D. Thomas, El Paso	El Paso, Texas, Oct. 20-22, '60
ama Medical Association	William R. Carter, Repton, Ala.	Douglas L. Cannon, Montgomery	Mobile, Ala., April 21-23, '60
gia, Medical Assn. of	Luther H. Wolff, Columbus, Ga.	Chris J. McLoughlin, Atlanta	Columbus, Ga., May 1-4, '60
Chap. Arthritis & Rheuma-			
n Foundation	John P. Mozur, Miami	J. Charles McKee Jr., Miami	
Hospital Conference	Oscar S. Hilliard, Ft. Oglethorpe, Ga.	Glenn Hogan, Atlanta	Miami Beach, May 3-7, '60
Am. Urological Assn.	N. Lewis Bosworth, Lexington, Ky.	J. L. Campbell, Orlando	Hollywood, 1961
heastern Surgical Congress	M. M. Copeland, Washington, D.C.	B. T. Beasley, Atlanta	

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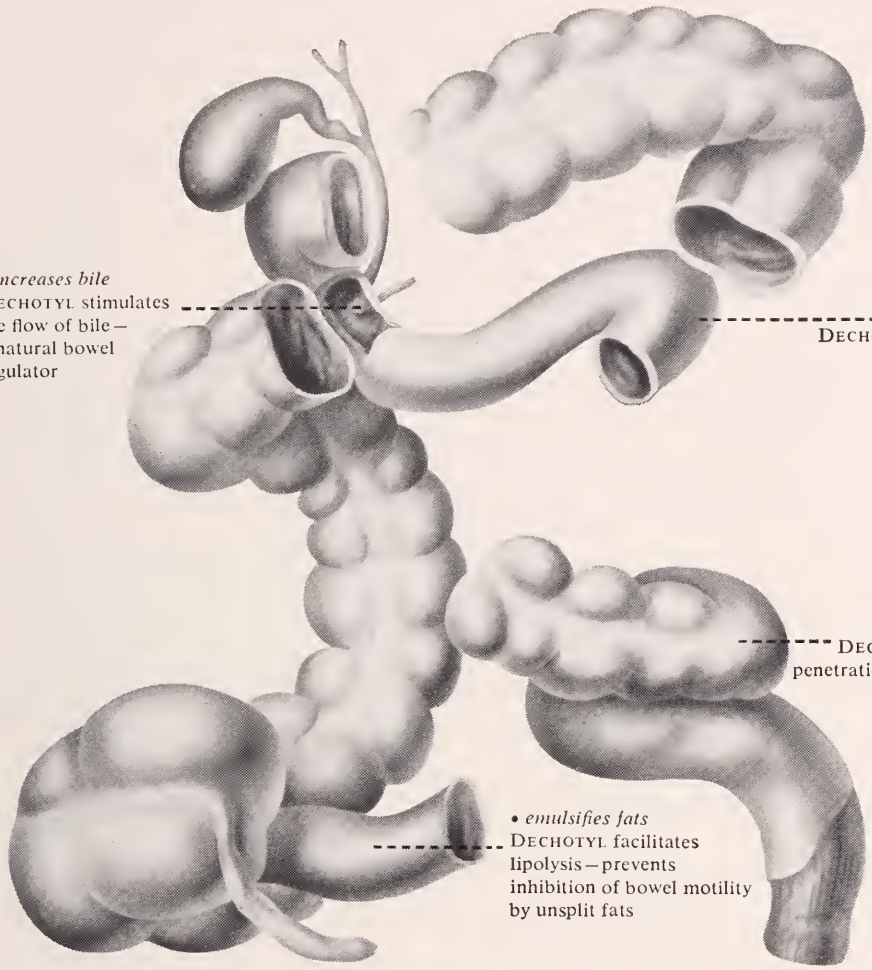
Monroe	Walter R. McCook, Key West	Joseph L. G. Lester Jr., Key West	1st Thurs.	16
Nassau	David D. Bennett Jr., Callahan	Cecil B. Brewton, Fernandina Beach	1st Thurs.	6
Orange	W. Dean Steward, Orlando	Robert W. Curry, Orlando	3rd Wed.	251
** Osceola*				
Palm Beach	Willard F. Ande, W. Palm Beach	Herman Baxt, W. Palm Beach	4th Mon.	131
Pasco-Hernando-Citrus	William H. Walters Jr., Lacoochee	W. Wardlaw Jones, Dade City	2nd Thurs.	18
Pinellas	Chas. L. Farrington, St. Petersburg	Whitman C. McConnell, St. Petersburg	1st Mon.	301
Polk	Charles Larsen Jr.,Lakeland	Clarence L. Anderson, Lakeland	2nd Wed.	128
Putnam	Roy E. Campbell, Palatka	Norman B. Edgerton, Palatka	2nd Tues.	14
St. Johns	S. Raymond Cafaro, St. Augustine	Joseph A. Shelley, St. Augustine	3rd Tues.	18
St. Lucie-Okeechobee-Martin	Joseph H. Batsche, Fort Pierce	Maltby F. Watkins, Ft. Pierce	3rd Thurs.	29
Sarasota	James E. Kicklighter, Sarasota	Thomas G. Dickinson, Sarasota	2nd Tues.	89
Seminole	Edwin Epstein, Sanford	Robert J. Smith, Sanford	2nd Tues.	18
Suwannee-Hamilton-Lafayette	Frederick T. Mickler Jr., Jasper	Irby H. Black, Live Oak	1st Sat.	10
Taylor	John H. Parker Jr., Perry	John A. Dyal Jr., Perry	Last Fri.	6
** Dixie*				
Volusia	Jas. J. Cunningham, New Smyrna Bch.	John J. Cheleden, Daytona Beach	2nd Tues.	101
** Flager*				
Walton-Okaloosa-Santa Rosa	Joseph C. Wilson, Ft. Walton Beach	Wm. W. Thompson, Ft. Walton Beach	3rd Tues.	31
Washington-Holmes	Walter H. Shehee, Chipley	L. H. Paul, Bonifay	Quarterly	5
			Total	2,625



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May, 1960
Vol. XLVI - No. 11

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LITERATURE SUPPLYING DETAILS OF DOSAGE AND ADMINISTRATION AVAILABLE ON REQUE

Bibliography: *(1) Maltby, G. L.:* J. Maine M. A. 48*:257, 1957. (2) Bray, P. F.:* Pediatrics 23*:151, 1959.*

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References: 1. Bunim, J. J., et al.: Arthritis & Rheumatism *1*:313, 1958. 2. Silverman, H. I., and Urdang, A.: Am. Prof. Pharm. *25*:531, 1959. 3. Rudolph, J. A., and Rudolph, B. M.: Ann. Allergy *17*:710, 1959. 4. Spies, T. D., et al.: South. M. J. *51*:1066, 1958. 5. Galli, T., and Mannetti, C.: Minerva med. *50*:949, 1959. 6. Segal, M. S., et al.: Ann. Allergy *17*:413, 1959. 7. Duvenci, J., et al.: Ann. Allergy *17*:695, 1959.

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VOLUME XLVI, No. 11

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• May, 1960

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This Journal is not responsible for the opinions and statements of its contributors.
Owned and published by Florida Medical Association.

Published monthly at Jacksonville, Florida. Price $5.00 a year: single numbers, 50 cents. Address Journal of Florida Medical Association, P.O. Box 2411, 735 Riverside Ave., Jacksonville 3, Fla. Telephone EL 6-1571. Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918. Entered as second-class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida, October 23, 1924.

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1. Projection from Vital Statistics, U.S. Government Dept. HEW, Vol. 48, No. 14, 1958, p. 398.
2. Modell, W.: Drugs of Choice 1958-1959, St. Louis, C. V. Mosby Company, 1958, p. 347.

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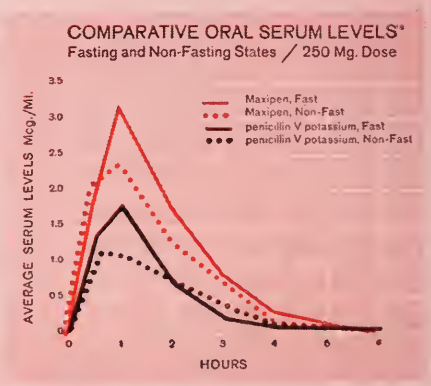

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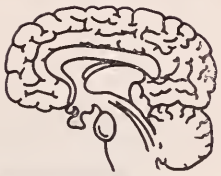

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References: 1. Goodman, L. S. and Gilman, A.: The Pharmacological Basis of Therapeutics, 2nd Ed., New York, Macmillan Company, 1955. 2. O'Reilly, P. O., Demay, M. and Kotlowski, K.: Cholesteremia and Nicotinic Acid. A.M.A. Arch. Int. Med. 100:797-801 (Nov.) 1957.

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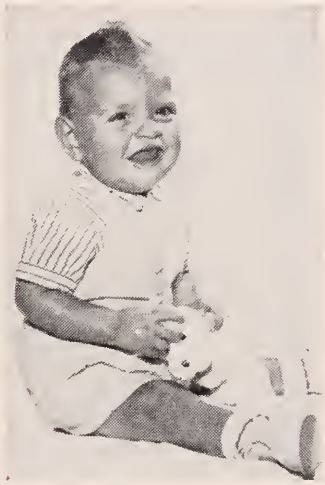
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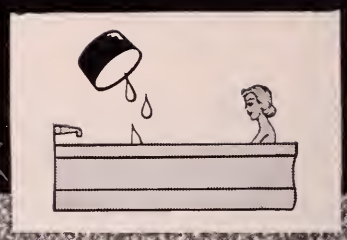

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References: 1. Kanof, N. B., and Blau, S.: *New York J. Med.* 59:2184 (June 1) 1959.
2. Smith, J. G., Jr.; Zawisza, R. J., and Blank, H.: *A.M.A. Arch. Dermat.* 78:643 (Nov.) 1958.

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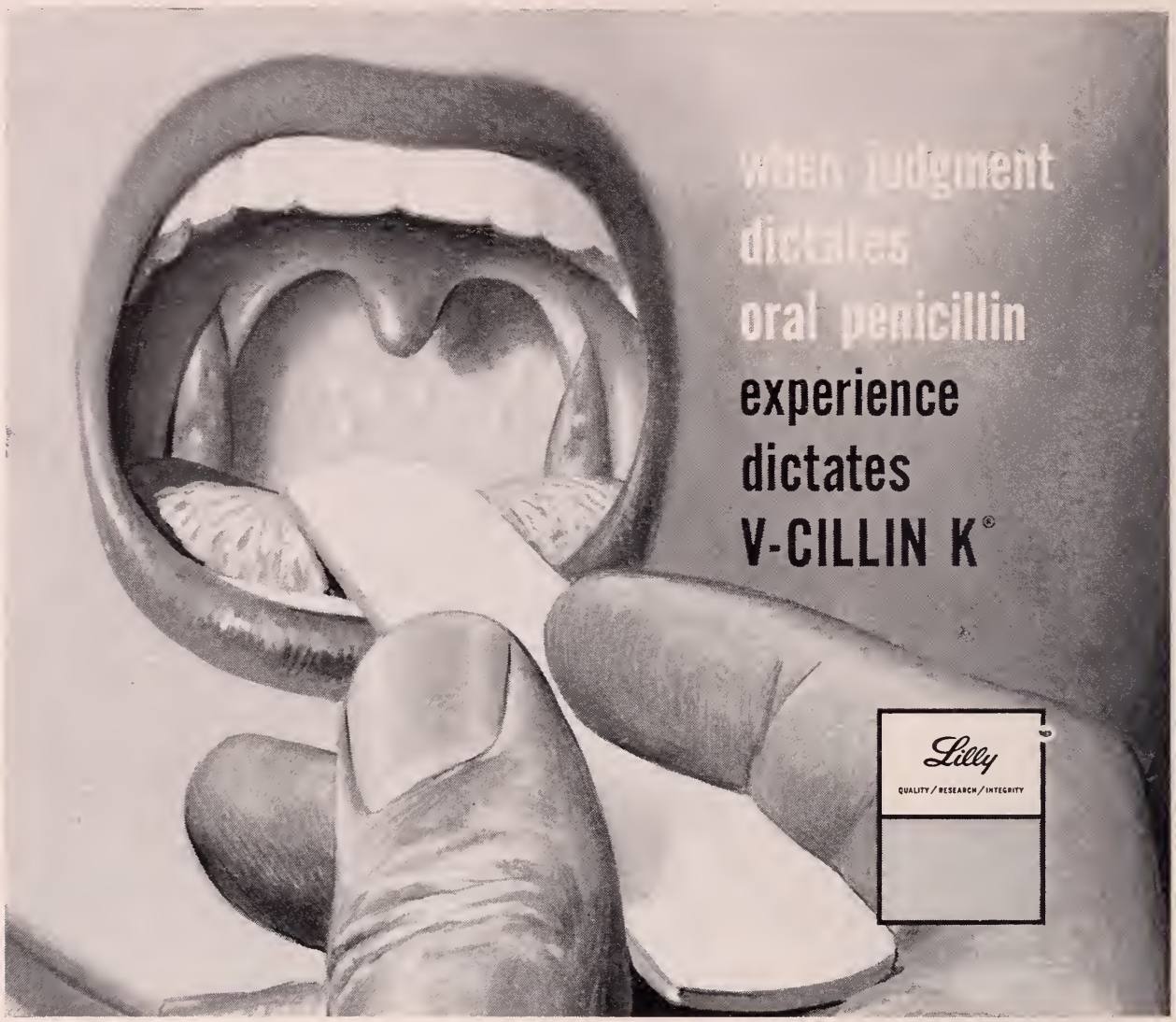

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1. Griffith, R. S.: Comparison of Antibiotic Activity in Sera Following the Administration of Three Different Penicillins, Antibiotic Med. & Clin. Therapy, 7:No. 2 (February), 1960.

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THE JOURNAL
OF THE
FLORIDA MEDICAL ASSOCIATION

Volume XLVI, No. 11, May, 1960

Facial Pain

C. MacKenzie Brown, M.D.
Tampa and Madeira Beach

Every time I consider facial pain or pain in the front of the head, I feel like a young medical student who wondered how so much anatomy could be crammed into such a small space.

Too many patients with pain in the front of the head become derelicts of doctors or casualties of dentists. Of the more than 2,000 patients with facial pain that I have seen, over 88 per cent had had their teeth extracted before they came to me. Analysis of this complicated, difficult subject should be beneficial to most physicians, dentists and a host of patients. We know that it is a mistake to embark on dental extractions or other operations on the head before precise diagnosis.

In no pain problem is it more essential to understand the patients by ferreting out the history and functional inquiry and by performing thorough physical and emotional examinations and appropriate laboratory procedures. They must be impressed sufficiently to be convinced that we have their interest at heart. By our thoroughness, they may gain confidence.

Anatomy

The regional anatomy should be familiar to all doctors concerned with facial pain. The fifth or trigeminal, seventh or facial, ninth or glossopharyngeal, tenth or vagus cranial nerves, the cervical sympathetic nerve supply and the upper cervical somatics may be involved by various disease processes that produce pain in the face or in the front of the head.

The trigeminal nerve is the largest cranial nerve and is the main sensory nerve supply to the face. It is well to review this anatomy because it helps one to understand the mechanism of pain associated with disease in this region.

The first or ophthalmic nerve passes along the wall of the cavernous sinus, then enters the orbit through the supraorbital fissure along with the oculomotor nerve. The ophthalmic nerve supplies the eyeball, lacrimal gland, conjunctiva, mucous membrane of the nasal cavity, skin of the nose, upper eyelids, forehead and anterior part of the scalp. It furnishes the sensory root of the nasociliary ganglion and gives rise also to a branch which passes backward to supply the superior surface of the tentorium cerebelli.

The second division or maxillary nerve passes through the foramen rotundum and reaches the face through the infraorbital canal. It gives rise to a recurrent middle meningeal nerve. The maxillary nerve supplies the maxillary sinus, cheek, nose, upper lip and teeth. It furnishes the sensory root of the sphenopalatine ganglion.

The third division or mandibular nerve reaches the skull through the foramen ovale. It supplies the teeth and gums of the mandible, the skin of the temporal region, part of the auricle, the lower lip, the lower part of the face and the muscles of mastication, also the mucous membrane of the anterior two thirds of the tongue and the floor of the mouth. It gives rise to the nervus spinosus which accompanies the middle meningeal artery. It supplies sensory fibers to the otic and submandibular ganglia.

Etiology and Therapy

Pain referred to various branches of the trigeminal nerve is of frequent occurrence. The

Read before the Florida Medical Association, Eighty-Fifth Annual Meeting, Bal Harbour, Miami Beach, May 4, 1959.

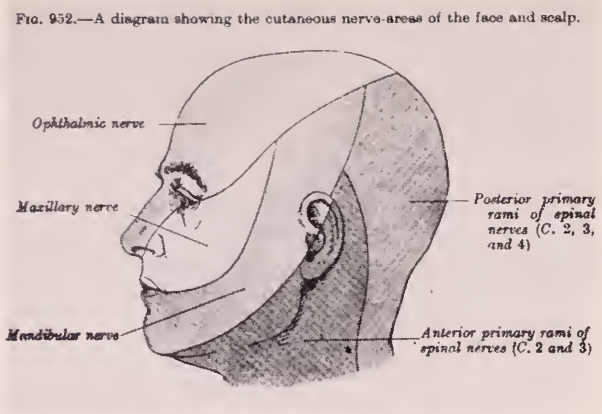

Fig. 1.—The three branches of the trigeminal nerve and the cervical somatics. (Gray's Anatomy: Lea & Febiger)

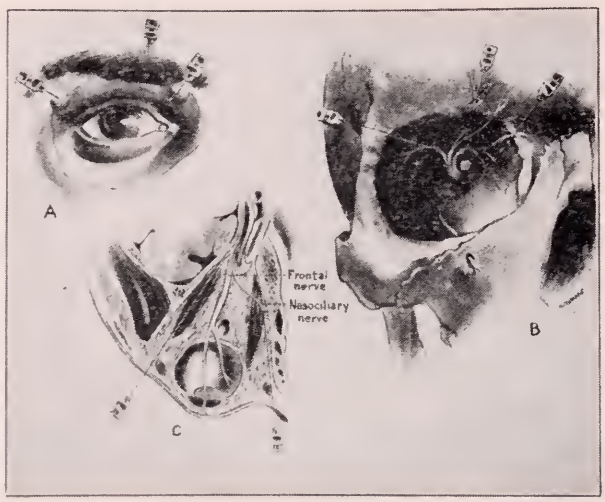

Fig. 2.—Lateral orbital, supraorbital block; medial orbital block is too dangerous because of optic nerve. (Bonica: The Management of Pain, Lea & Febiger)

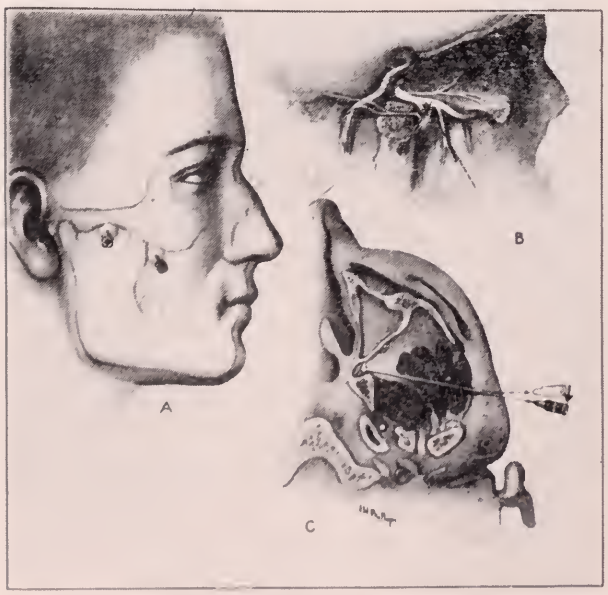

Fig. 3.—The pterygopalatine fossa is in front of the pterygoid plate. (Bonica: The Management of Pain, Lea & Febiger)

commonest examples is the symptomatic neuralgia associated with dental caries. Among the other common causes of trigeminal pain in the area of the ophthalmic nerve are acute glaucoma and disease of the frontal or ethmoidal sinuses. Malignant tumors or empyema of the maxillary sinuses or disease about the inferior conchae or septum of the nose may cause pain in the maxillary distribution. Pain in the ear may be due to disease in the distribution of the mandibular nerve, such as ulcer or cancer of the tongue (by the auriculotemporal nerve).

Symptomatic trigeminal neuralgia may express itself in paroxysmal facial pain. This is accompanied by sensory loss usually and sometimes paralysis of innervated muscles. Specific nerve block may ease or cure some of these pain syndromes such as muscle spasm or charley horse, Bell's palsy, herpes zoster, mandibular joint pathologic conditions, sphenopalatine neuralgia and sometimes migraine. Nerve blocks with absolute alcohol may be used to relieve the pain due to tumors near the foramen ovale and foramen rotundum or other tumors producing facial pain. In addition facial pain may be due to disseminated sclerosis, gummatous meningitis, tabes dorsalis, periostitis, erysipelas, middle fossa brain tumor, pons hemorrhage or sclerosis, emotional stress, mental disease and allergy. Symptomatic trigeminal pain must be differentiated from primary trigeminal neuralgia or tic douloureux.

The latter is a distinct clinical entity characterized by episodes of sudden, shooting, stabbing, knifelike pain in the face with no clinical or radiologic abnormalities. Usually there is a trigger point. Remissions become briefer as the patient gets older unless there is adequate treatment by specific nerve block or a neurosurgical procedure. This idiopathic painful misery, tic douloureux, sometimes involved the seventh, ninth or tenth cranial nerves, although involvement of the fifth is most usual.

Narcotics must be avoided. While it is most important to search for the significance of the symptoms being ameliorated, drugs such as sedatives, tranquilizers and other analgesics may be especially helpful—Trilafon, Trancopal, phenobarbital and so on. Nerve blocks when indicated with or without these drugs make narcotics unnecessary.

Usually it is essential to stabilize the emotions of patients with facial pain. Thoroughness of investigation, coupled with kindness and estab-

lishment of confidence, goes a long way. Diagnostic procedures should be sufficient to permit the physician to assure the patient about his organic and emotional state. In severe cases of psychoneurosis with the patient's understanding that no serious structural disease is present and with an explanation of the mechanism of his pain problem, symptoms may disappear.

Some patients may be more receptive to suggestion after intravenous barbiturates, thus unlocking the patient's mind and discharging emotional conflicts. Intravenous Nembutal plus Desoxyn is a most helpful technic and may facilitate ventilation. As in other recalcitrant pain problems, the patient may be benefited by hypnosis. In this state of increased suggestibility the turmoil in the patient's mind may be eased, and the subconscious mind may receive an enduring positive thought.

Conclusion

In the management of facial pain all medical doctors realize the importance of a careful medical evaluation along with neurologic, allergic, ophthalmologic and otolaryngologic studies. When the cause is obscure, roentgenograms of the skull, spinal fluid examination, an arteriogram, an oxygen encephalogram and an electroencephalogram may be of definite value.

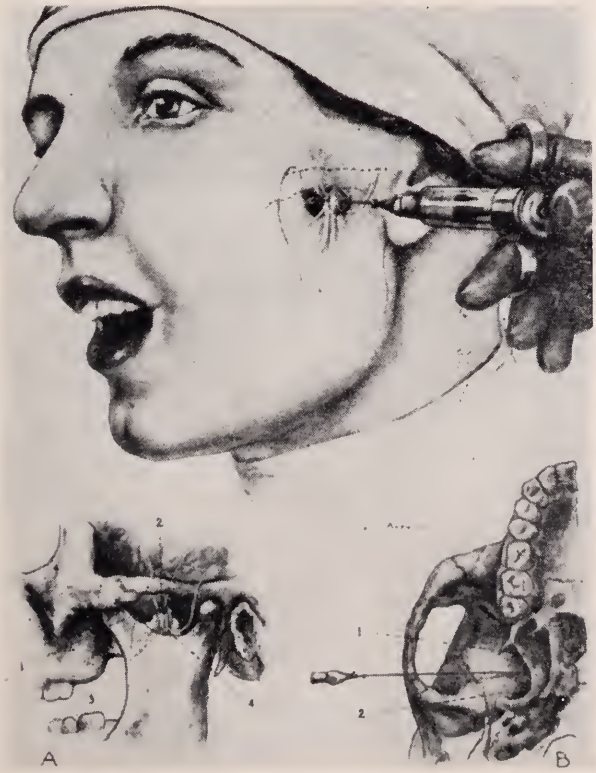

Fig. 4.—The foramen ovale is behind the pterygoid plate. (Pitkin: Am. J. Surg. 8:239)

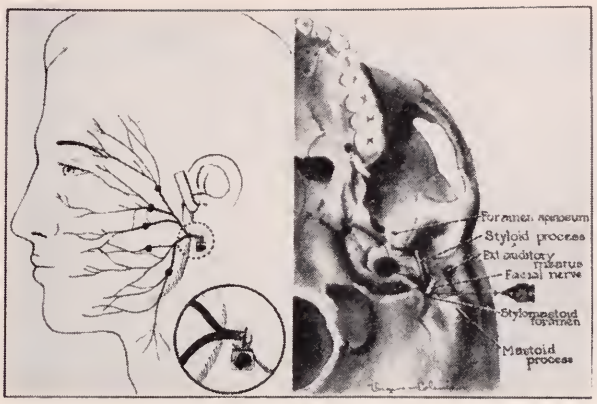

Fig 5.—The stylomastoid foramen is midway between the mastoid and the styloid process. (Bonica: The Management of Pain: Lea & Febiger)

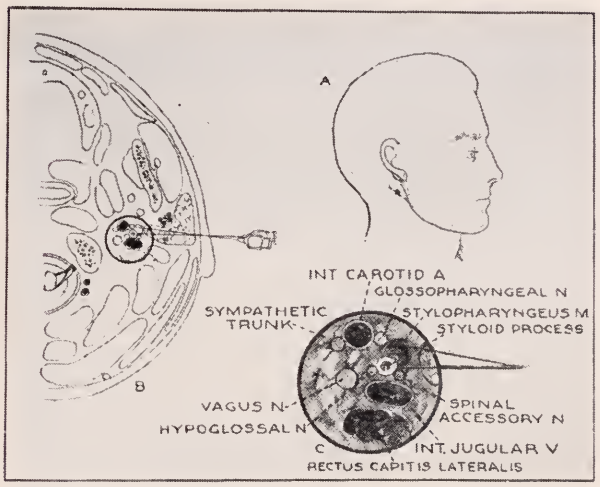

Fig. 6.—The glossopharyngeal nerve is anterior to the styloid and lateral to the carotid artery. (Bonica: The Management of Pain: Lea & Febiger)

Familiarity with the regional anatomy is of basic importance. Specific nerve block therapy and other therapeutic improvements eliminate the need of narcotic drugs.

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Discussion

Dr. Breckinridge W. Wing, Orlando: I am sure that all of us who see patients with pain in the region of the face have benefited from hearing Dr. Brown's paper. Apparently he would emphasize that a thorough investigation by means of a carefully obtained history, physical examination, and laboratory studies including roentgenograms will more often than not lead to the diagnosis of the cause of the pain syndrome, and that, with careful technics, various nerve blocks about the face and neck will often give pronounced, more or less permanent relief of the complaints.

In the summary of the paper which I received from the Association office, there was little attention given to any of the nerves involved except the trigeminal. I cannot explain this apparent omission unless it is because the great majority of the pain syndromes under discussion involved this nerve.

Dr. Brown mentioned the desirability of avoiding chronic medication with the narcotic drugs in patients with facial pain. While I have had a very limited experience with any of these procedures, I have frequently heard it said that in patients who are already addicted to one of these because of pain, relief of the pain through the medium of nerve blocks is rarely successful in breaking the addiction, and I wonder if Dr. Brown would like to comment on this question.

I have enjoyed hearing Dr. Brown's paper and am grateful for this opportunity to discuss it.

DR. EDWARD J. SULLIVAN JR., Jacksonville: In my practice of neurosurgery the majority of facial pains are due to emotional stress rather than an organic cause and sometimes mask a depression. I hope Dr. Steele will comment on this in his paper which follows. It is most important to avoid operating in these cases since the condition known as anesthesia dolorosa or painful anesthesia may develop.

I should like to second Dr. Brown's comment that narcotics must be avoided. This is true in facial pain just as in any other chronic nonfatal painful condition. A better way of relieving pain in organic conditions is usually available, and in the case of psychogenic pain narcotics quickly lead to addiction and aggravation of the complaint.

Neurosurgeons find that alcohol block in tic douloureux is useful both as an initial treatment and as a therapeutic test in the doubtful case. Successful relief of pain supports the diagnosis and allows the patient to experience temporary facial numbness. Most patients gladly trade the pain for the numbness. Successive alcohol blocks, however, tend to become less effective because of scar formation. This leads finally to the necessity for neurosurgical relief. While it is true that the posterior root of the fifth nerve can be successfully sectioned even in the very old and the very feeble patient, it is well not to procrastinate too long before advising surgery once the tic pain becomes severe and frequent and interferes with nutrition. Finally, I should like to point out that Dilatin Sodium alone or in combination with mephenesin may sometimes bring about effective control of tic pain.

I should like to congratulate Dr. Brown on bringing this subject to the attention of this gathering.

The Contribution of Occupational Therapy To Patient Care

ALICE C. JANTZEN, O.T.R.
GAINESVILLE

Occupational therapy uses creative and constructive activity to aid in the evaluation and treatment of patients. Work and play have long been recognized for their value in maintaining health. These activities have also demonstrated their effectiveness as therapeutic measures for patients with physical, mental and emotional illnesses. The practice of occupational therapy is medically supervised, and a patient receives this form of treatment upon the written request or prescription of a physician. The types of services provided by occupational therapy and suggestions as to the appropriate written information which the physician should provide for the therapist are discussed here.

Types of Services

In occupational therapy the patient of necessity becomes an active participant in his own treatment since he performs the activity himself. He is thus helping himself to alleviate or overcome his physical and emotional problems. The range of activities which will achieve the appropriate therapeutic goals for each patient depends both on his actual diagnosis and also on his personality, interests, aptitudes, and educational and occupational background. It is apparent that an activity which may be appropriate for a six year old child might well be unacceptable to a 40 year old man with the same diagnosis. Thus, the choice of the activity for a particular patient is usually left to the discretion of the occupational therapist. The therapist knows the physical and psychological components inherent in the wide variety of activities used, and is able to analyze and to adapt these activities in relation to an individual patient and to his particular problem.

Using activities as tools, occupational therapy can therefore provide two major services for the physician in the management of his patients. These services may be divided broadly into evaluation and treatment. The following illustrations give an indication first of evaluation procedures and secondly of treatment procedures which are employed in occupational therapy.

Evaluation Procedures

In a permanently disabled patient it is pertinent to know the extent of his own daily activities which a patient can perform, or is capable of

From the J. Hillis Miller Health Center, University of Florida, Gainesville

learning to perform. In a testing program, the occupational therapist will evaluate the patient's abilities in feeding himself, in grooming and in dressing himself. The patient can be tested on certain communicative skills such as writing and typing, and also in the use of various mechanical devices such as locks and switches. In evaluating a child, the therapist can provide information as to his level of motor development in relation to normal children of comparable age.

Secondly, occupational therapy can contribute to a better understanding of the emotional problems of psychiatric patients. Many of these patients are unwilling or incapable of communicating their problems to the psychiatrist. In these instances, the occupational therapist can provide them with various creative and constructive activities through which they may express themselves nonverbally. The therapist is also able to observe the patient's social behavior over an extended period of time, both individually and in group situations. These observations of a patient's relationship to others, coupled with his manner of performance and his work products as projective symbols of his conflicts can contribute to the psychiatrist's determination of the personality dynamics and appropriate treatment approach for each patient.

A third type of evaluative service to which occupational therapy contributes is that of prevocational exploration. Since the activities require for their performance various levels of skill which can be related to occupations, information on manual dexterity, work tolerance, work habits, aptitudes, ability to comprehend directions and other job-related factors can be determined while the patient is in occupational therapy. This evaluation will give some indication as to whether a patient will be able to return to his occupation, or, if he is unable to do so, will give an indication of other vocational possibilities for him. It should be mentioned that the largest single occupational group seen in the hospital is the disabled housewife, and the occupational therapist is capable of evaluating the extent to which such a person is capable of resuming her role in the home.

Treatment Procedures

In providing actual treatment for patients, the objectives and function of occupational therapy are restoration of function in its broadest meaning. Some examples of this follow.

For the person with a physical problem, the activities will be used to improve his physical capacities. There may be need to increase the range of movement of a specific joint, to increase the power of a particular muscle group, to establish coordinated action between groups of affected muscles, or to increase endurance. In working with such patients the occupational therapist will, if it is warranted, adapt the activity to accomplish the treatment aims. He may also train the patient in the use of special splints and devices which will make the patient as independent as possible in his activities. Since the occupational therapist is himself skilled in the use of a wide variety of tools and materials, he may also design, adapt and build equipment which will serve to improve the patient's functional abilities.

In occupational therapy for the psychiatric patient, both the activities used and the personality of the therapist are of major importance in achieving the desired objectives. The activity will be selected with a view to satisfying the patient's basic emotional needs, that is, providing an acceptable outlet for aggression, for dependency, for sublimation and the like. The therapist will also assume the attitude which has been determined by the psychiatrist as the appropriate one to help alleviate the patient's emotional problems and further his emotional growth. Furthermore, the occupational therapist is not only trained in this form of role-playing when working with patients, but also has an understanding of group dynamics and the employment of the patient group as a means of treating the individuals who make up the group.

The objectives of treatment used for psychiatric patients may also be employed for medical, surgical and pediatric patients who are experiencing emotional problems and difficulties in adjustment because of their major physical diagnosis. Although a particular activity may be incapable of treating directly certain physical diseases such as rheumatic fever, tuberculosis, cancer and diabetes, nevertheless the activity may be successfully used in helping the patient adjust to and accept a drastic change in his way of life.

Information Physicians Should Provide

A request by the physician for occupational therapy should, first of all, indicate the objectives desired from treatment. When possible, it is helpful to have indicated both the ultimate goal and the immediate goal for a patient. For example,

the ultimate goal may be return to his job; the immediate goal may be to increase the strength and dexterity of the left hand. Such information lets the therapist know what is considered to be the immediate problem which needs consideration, but also allows the therapist to plan ahead for the patient over an extended period of time. The physician, therefore, in writing a proper prescription for occupational therapy, will indicate the objectives desired, the precautions to observe, the frequency and duration of treatments, and when pertinent, as for psychiatric patients, the attitude the therapist should assume. A request for occupational therapy differs from other forms of prescriptions in that the actual treatment measure, the activity, is not indicated for the reasons mentioned earlier.

Moon Talk

The Cyclic Periodicity of Postoperative Hemorrhage

EDSON J. ANDREWS, M.D.
TALLAHASSEE

It has often occurred to me, as it has to many others performing eye, ear, nose and throat surgery, that at certain times the human body has a greater predilection to excessive bleeding than at others. There are days in the operating room when hemorrhage is of no import; at other times, persistent and annoying bleeding is the rule of the day. Why is this so? Of course, our laymen friends tell us that it is so because the signs are not right; our professional colleagues say it is just one of those things.

Several years ago the thought was presented to me by my nurse that perhaps the moon was the influencing factor. Of course, this sounded utterly ridiculous; but unbeknown to me, she had kept a record of my bleeders on a calendar and proceeded to show me, much to my amazement, that their bleeding was, indeed, coincident with the full moon. In fact, these bleeders were so definitely grouped according to the lunar cycle that we decided to collect some additional data in a more scientific and complete manner rather than merely to circle a date on the calendar.

Physicians have all heard for years the many and various myths relating the phases of the moon with health, not only mental but physical, particularly with regard to bleeding. Who among you has not heard the story that most farmers will not consent to castration of their animals during a full moon for fear that they would bleed to death? Who has not heard a patient say that he did not want to be operated on at such and such a time, as the signs were not right? Was all this fact or fiction?

The literature was combed; the Quarterly Cumulative Index Medicus, the American Medical Association Library and the medical department of the John Crerar Public Library in Chicago were consulted, but nowhere could I find that any work had been done to prove or disprove these myths. The scientists all agreed that it was folklore and superstition and that there was no scientific basis for such an hypothesis, but unfortunately they had never bothered to collect any data to substantiate their claim. I decided to do so, and records were kept on all our tonsillectomy cases during the years 1956 through 1958; they numbered just over one thousand.

Bleeders were classified as those patients who had to be returned to the operating room, those who bled sufficiently postoperatively to require medical management, namely, Premarin, Koagamin, et cetera, and those who bled persistently on the operating table, requiring unusual means of control such as suture. The dates of these episodes of bleeding were charted according to the phase of the moon.

It is evident in figure 1 that the preponderance of these bleeders occurs in the vicinity of the full moon and drops down to an insignificant

Read before the Florida Society of Ophthalmology and Otolaryngology, Bal Harbour, Miami Beach, May 2, 1959.

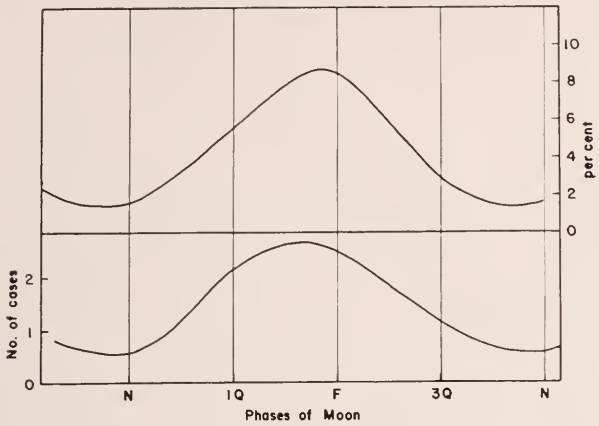

Fig. 1.—Lower curve represents tonsil and adenoid bleeders in the Tallahassee Memorial Hospital data, 1956-1958, 44 cases, averaged for seven day periods centered on each moon phase. Upper curve represents per cent of total number of operations in which patients were classified as bleeders, averaged in the same way.

number at the new moon. In fact, 82 percent of our cases occurred in an interval between the first quarter and one day before the third quarter. What makes this observation even more astounding is the fact that there were fewer admissions during the time of the full moon, when we had the most bleeders. Perhaps laymen know more about this than we do and are reluctant to enter the hospital at this time. The upper curve of this graph plots the percentage of bleeders against the number of admissions and this only serves to accentuate the preponderance of bleeders that occurs at the full moon.

Combined Tonsil and Adenoid Series

Thinking that perhaps our data might be colored by wishful thinking, I was fortunate to obtain from Dr. Carl S. McLemore of Orlando, who had been compiling similar statistics, the dates of his tonsil bleeders. When they were plotted in a similar manner against the lunar cycle, the curve followed the same pattern, as is shown in figure 2. The dotted curve represents the bleeders as furnished by Dr. McLemore. The solid line is a summation of both series of cases. The astounding preponderance of hemorrhage at the full moon and the relative absence at the new moon are plainly evident.

Peptic Ulcer Series

Carrying our suspicions a step further, it occurred to me that if this curve held true for throat bleeding, it should hold true for other types of bleeding. Consequently, we took the dates of all cases for the same period in which the patient was admitted for bleeding peptic ulcer and plotted them in a similar manner. Figure 3 shows the definite trend of increase in the area of the full moon. When one adds all these three sets of data together, a convincing curve results. By this time the witches were really stirring the brew.

Discussion

What does all this mean? Can these amazing observations be backed up by any scientific fact? Dr. L. J. Ravitz, in experimenting on human subjects at Yale University and Duke University and in the Veteran's Administration, found that on attaching electrodes to various positions in the body, there were rhythmic, cyclic variations in

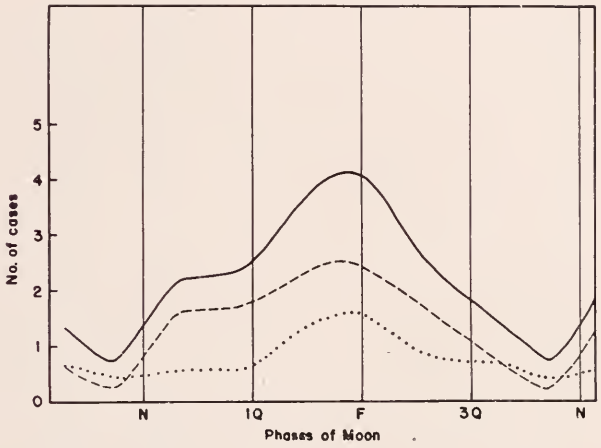

Fig. 2.—Tonsil and adenoid bleeders related to phases of the moon. Dotted curve represents McLemore data, 1950-1956, 24 cases. Dashed curve represents Tallahassee Memorial Hospital data, 1956-1958, 44 cases. Solid curve represents a summation of these data, 68 cases. All data are smoothed by taking seven day averages every fourth day.

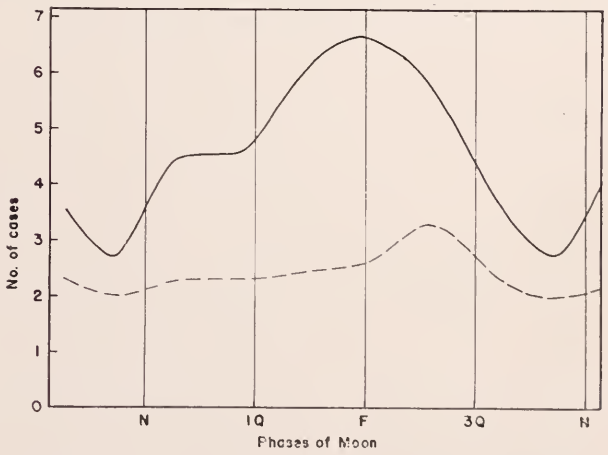

Fig. 3.—Tonsil and adenoid bleeders and ulcer bleeders related to phases of the moon. Dashed curve represents Tallahassee Memorial Hospital ulcer bleeders, 1956-1958, 66 cases. Solid curve represents total number of tonsil and adenoid bleeders (Tallahassee Memorial Hospital and McLemore data) plus ulcer bleeders, primarily 1956-1958, 134 cases.

electrical potential which varied during the month and that the greatest increase in potential was during the full moon. The same cyclic variations were found in plants. In humans they coincided with swings in mood, as in a feeling of ill or well being. They also found there was a consistent variation in potential during each hour and during each 24 hour period. These changes were more pronounced in severely maladjusted persons.

Dr. F. A. Brown at Northwestern University has done some remarkable research along these lines. He found 24 hour, 28 day, and annual cycles in body temperature, blood sugar, blood count, metabolism, and intraocular tension. By an ingenious device, he was able to measure metabolism in plants and animals, carrying it down to the metabolism of a single cell. The metabolism in every single one of the plants and animals studied varied, of course, during a 24 hour cycle; but, most startling, it varied with the lunar cycle, being lowest at the new moon and highest at the third quarter. In fact, it was 20 per cent higher at the third quarter. The daily cycles were exaggerated by the monthly cycle.

Figure 4 illustrates graphically the variation in plant metabolism with the lunar cycle. This variation followed the same pattern for all animals studied.

To eliminate the influence of light, temperature, and barometric pressure, plants were hermetically sealed in containers with constant conditions of environment. Despite this provision, the cyclic variations continued.

All plants and animals predict a barometric pressure change by a change in their metabolism 48 hours before that change in barometric pressure occurs, and they make this prediction even in sealed containers. It is also possible to tell outside temperature in these sealed containers as the metabolism rises (even though the temperature is constant in the containers). Metabolism also changes with the amount of cosmic radiation. Dr. Brown's conclusion was that "there is incontrovertable evidence that excluding all known forces influencing living things, there is a cyclic information in the form of radiation penetrating all ordinary containers that impresses all living things corresponding to atmospheric and lunar periodicity."

During the years 1955-1956 there was a great increase in cosmic radiation, and during this period the metabolic cycles were increased.

Figure 5 demonstrates the variation of metabolism with the amount of cosmic radiation, the metabolism being lowest when radiation is highest.

If Dr. Brown's work is correct, the human must also have cyclic metabolic changes, temperature, blood sugar, and blood count, that could account for altered physiology at the height of the lunar cycle and he, too, must anticipate barometric pressure changes by 48 hours.

If metabolism is so labile as to change with the lunar cycle and with the amount of cosmic radiation, is it not reasonable to assume that changes in the vascular bed and changes in clotting and bleeding time can also occur?

It has been known for a long time that barometric pressure changes have a great deal to do with health. Kincade in 1953 stated: "Epistaxis may assume almost epidemic proportions at times of weather change." Utrata has shown that there are more postoperative hemorrhages and more duodenal and gastric hemorrhages during the passage of a cold front. Peterson in his classic work, The Patient and the Weather, proved that there were more coronary deaths, more migraine attacks, more eclampsia, and more asthmatic deaths at the passage of a cold front. He found that as the barometric pressure went up, body temperatures went down. There were changes in blood sugar and basal metabolic rate, and most important, a rise in blood pressure and an increase in capillary permeability. These changes do not occur, however, in mere temperature changes alone. The blood carbon dioxide is down, the blood pH is down, the nonprotein nitrogen rises, blood sugar and cholesterol rise, the platelet count goes up, and there is an increase in the sedementation rate. There is a shunting of the blood from the peripheral to the deep vasculature. The circulatory system bears the brunt of the regulatory system.

There is an old superstition that there are more barometric pressure changes at the time of the full moon. The Department of Meteorology at Florida State University will not say — does not know.

It might be interesting to mention a few classic examples of how the moon affects animal life. Off Bermuda, shrimp swarm in the waters just before midnight on the day of the new moon, once a year, and are then seen no more. Once a year, the grunion swarm onto the beach in California at high tide, which, of course, is

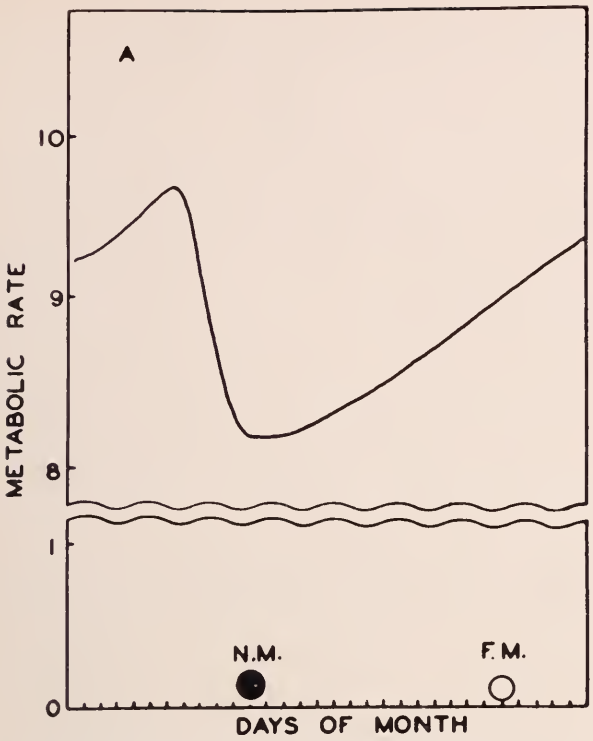

Fig. 4.—The variation in average metabolic rate in the potato with time of the lunar month. (After F. A. Brown Jr.)

moon-controlled. The Australian reef heron lives 30 miles inland from its feeding ground on the coast; it feeds at low tide only and every day leaves its roost just 50 minutes before low tide to reach the coast at the proper time.

Ebers in 1938 and Sadger more recently reported there was more somnambulism on moonlit nights. All through the literature I find the statement that there are more epileptic attacks during the full moon, but I can find no proof. In fact, the word epilepsy comes from the Greek meaning "to seize upon from the moon." It is said that there is more arson and that there are more crimes committed on the full moon, but the Federal Bureau of Investigation would give me no statistics to bear out this statement, and it cannot be verified. Dr. Bolton, head of the Psychiatric Department at Temple University said, "It has long been accepted by psychiatrists that the moon is known to have a serious effect on the minds of persons afflicted with nervous disorders." Kolisko did some research and wrote a book, Moon and the Growth of Plants. He proved that there is a definite connection between moon phases and planting. Over a nine year period, he found that corn planted two days before the full moon is definitely larger than corn planted two days after. Also, peas withered more quickly when planted on the new moon.

It has long been known that bleeding is markedly increased during menstruation, and who would deny that menstrual rhythm does not match the lunar cycle?

Could it be that variations in the endocrine system, which occur on a cyclic basis, could be a factor in this periodic bleeding? After all, Premarin works in our hands in the control of hemorrhage.

Repeated bleeding times taken in a hemophiliac certainly suggest that there is a 28 day cycle.

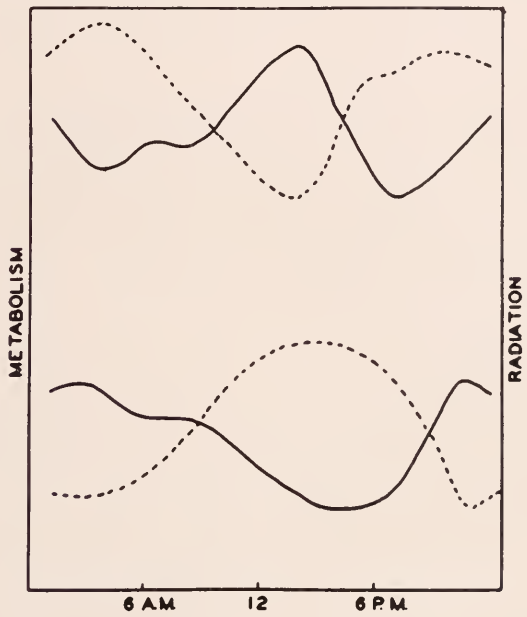

Fig 5.—Comparison of the average daily cycles of cosmic radiation (broken lines) and fiddler crab metabolism (solid lines) for a single summer month in each year, 1954 (upper pair of curves) and 1955 (lower pair of curves). (After F. A. Brown Jr.)

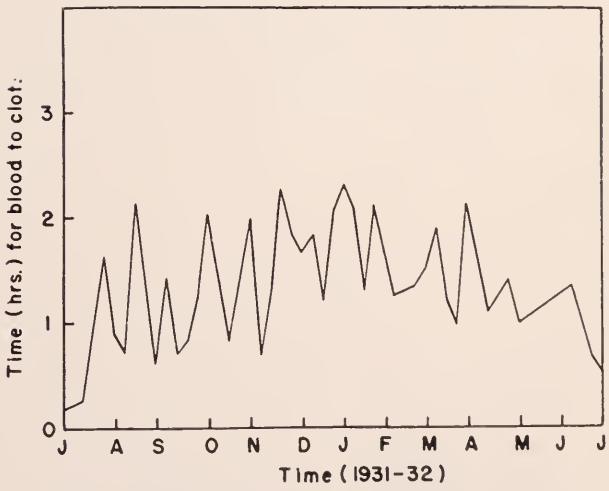

Fig. 6.—Variations in blood clotting time from July 1931 to July 1932. Determinations made weekly. (After W. F. Petersen)

Figure 6 is a record of coagulation times in one person, and I think all will agree that a monthly rhythmic periodicity exists. It has also been proved that there is a 28 day cycle in platelet count.

Incidentally, I had always heard that there were more babies born on the full moon, but my obstetrical friends said there were not. Just because I was stubborn, I charted the births at Tallahassee Memorial Hospital for the same period, 1956, 1957 and 1958, and plotted them against the moon phases. Four hundred and one babies were born within two days of the full moon, 375 within two days of the new moon, and 320 within two days of the first quarter. Draw your own conclusions.

Could all this be an inherent rhythm of the tides — a remnant of our prehistoric existence, dating back to our emergence from the sea? A doctor in England claims he has data to prove that at the ebb of the tide there occur more natural deaths than at any other time.

Conclusion

It would seem then that we do have evidence that prolonged bleeding at the full moon can occur and pretty good evidence that it is possible for human physiology to be so altered that it might explain periodic, prolonged bleeding. In the face of the evidence, however, it would seem that it might be well to investigate this possibility in more detail before we say "just superstition."

There is a large and widespread folklore about the moon, and somewhere beneath it may lie a few sparks of yet unknown truth. Folklore, even of the silliest sort, has sometimes proved to have a valid, if misunderstood, basis. The ancient practice of smearing wounds with nasty, moldy substance looked ridiculous until Sir Alexander Fleming discovered penicillin. The nature of the moon's influence is unproved; possibly the inherent protoplasmic rhythms may have lunar periodicity.

If all this sounds too much like sorcery, let me, in conclusion, quote from Spencer, "There is no bar to knowledge greater than contempt prior to examination." I hope this stimulates someone better qualified than I to analyze in greater detail the amazing association of the full moon and the increased incidence of bleeding. Meanwhile, because these data have been so conclusive and convincing to me, I threaten to become a witch doctor and operate on dark nights only, saving the moonlit nights for romance.

Acknowledgement and sincere thanks are herewith expressed to Holbrook Landers, M.A., Assistant Professor of Meteorology at Florida State University, whose invaluable technical assistance made it possible to convert these data into graph form.

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Antibody Responses of Children To Asian Influenza Vaccine

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Howard K. Edwards,† Martin Mangels Jr.,
and
F. M. Wellings
CORAL GABLES

The rapid spread of Asian influenza in 1957 created great demand for a vaccine which was then in very short supply. It therefore appeared desirable to determine whether smaller inocula than usually recommended would be adequate for immunization. Unpublished data obtained by one of us in 1949, as well as findings of Bruyn, Meiklejohn and Brainerd,[1] suggested that 0.1 cc. of vaccine given intradermally might succeed in stimulating antibody formation to the new strain of virus. This report presents the results of serological tests on serum specimens collected from children and from young and middle-aged adults given Asian influenza vaccine, with intradermal variations in immunization procedures.

Materials and Methods

Persons in different age groups, all residing in Dade County, were included in the study. Residents of four homes for children and students of Miami Military Academy constituted the pediatric group (through 12 years of age). Representative of young and middle-aged adults were older students of the Military Academy and employees of Eastern Air Lines, Inc., Pan American World Airways and Dade Reagents, Inc. A parallel study carried out in Jamaica by Dr. Louis Grant and Mr. Keith Jones, in cooperation with us, had access to small groups of young children and adults.

Monovalent vaccine was obtained from three pharmaceutical houses and polyvalent vaccine from a single such source. These preparations varied in potency from 200 to 400 chick cell agglutinating units (CCA) per milliliter. Intradermal inoculations were with 0.1 ml.; subcutaneous vaccination was with 0.5 ml. for children and 1.0 ml. for adults. All booster inoculations were made intradermally. Blood specimens were obtained prior to immunization and at specified intervals thereafter.

Serological procedures consisted of complement fixation (CF) and hemagglutination inhibition (HI) tests, and all serum specimens from a given group were usually tested simultaneously. The antigen used in both procedures was the A/Jap/305/57 strain of Asian influenza virus, obtained from the Communicable Disease Center of the United States Public Health Service. This virus was in the form of allantoic fluid and had not been passaged through any laboratory host other than the embryonated egg. In our hands this material proved relatively insensitive to nonspecific serum inhibitors and provided a more sensitive antigen for antibody detection than did an egg-ferret-mouse-egg passaged strain.

A number of variations in the HI test were evaluated, including pretreatment of sera with periodate as well as the use of various species of red blood cells (chick, sheep, human). In addition, the usual procedure was compared with a "delayed" test in which serum and virus mixtures were refrigerated overnight before the addition of the red blood cells. Based on results with paired sera from immunized persons and from subjects with Asian influenza infections, the procedure of choice—as regards specificity of measurement and the ability to detect antibody rises—was the "delayed" test, utilizing human red cells and untreated serum (that is, no periodate). This procedure was routinely used as a diagnostic test. In 73 instances there was serological evidence of Asian influenza infection; in 93 per cent of these, significant antibody rises (fourfold or greater) were demonstrated by both CF and HI. In all cases in which Asian influenza virus was isolated from the patient, both CF and HI tests gave positive results.

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†Deceased.

Table 1. — Serological Response of Children to Asian Influenza Vaccine as Measured by HI Test

Initial Immunization	Booster (20 CCA)	Number Tested	Serum	Distribution of Titers*				Net Response**		
				Neg-5	10-20	40-80	160 or Greater	Number Positive	Number Partial	Number Negative
Intradermal 20 CCA	None	116	S1	69	40	7		78	22	16
			S2	16	40	38	22			
	10 days	24	S1	16	8			10	10	4
			S2	5	15	2	2			
	4½-6 wks.	25	S1	12	12	1		24	1	0
			S2	0	2	15	8			
Subcutaneous 100 CCA	None	11	S1	8	3			9	2	0
			S2	0	5	4	2			
	10 days	8	S1	6	1	1		7	1	0
			S2	0	0	5	3			

* Titers expressed as reciprocal of initial serum dilution.
** Positive response = fourfold or greater rise in titer.
Partial response = only twofold rise in titer.
Negative response = no rise in titer.

S1 = Preimmunization sera.
S2 = Sera obtained 3 to 8 weeks after final immunization.

The HI procedure readily lent itself to combination with the CF test, the technic for which has been described previously.[2] The final procedure evolved was as follows:

Paired heat-inactivated sera were diluted in twofold steps in veronal buffer (pH 7.4) and appropriate aliquots were measured out for the CF and HI tests. The respective antigens in appropriate concentrations were distributed, and complement added to the CF tubes. Conventional controls were set up for both procedures, and all mixtures placed at 4° C. After overnight refrigeration, sensitized sheep cells were added to the CF test while HI mixtures received human type 0 cells. The final constituents of the two tests were:

	CF	HI
Serum	0.1 ml.	0.2 ml.
Antigen	0.1 ml.	0.2 ml. (4-8 HA units)
Complement	0.2 ml.	none
Red blood cells	(1½-2 units) 0.2 ml. sensitized sheep	0.2 ml. 1% human

Following addition of red cells, the tests were incubated at 37° C. for 30 minutes, then at room temperature for 30 to 60 minutes before being read.

Many of the sera from persons in the program were tested repeatedly over a period of several months, and the procedure yielded reproducible results as regards the significance of antibody responses demonstrated. In addition, a high degree of replication of CF and HI titers on different test dates was obtained.

Results

In view of the alleged poor immunological response of children to Asian influenza vaccine, the serological results were rather surprising. The HI tests, summarized in table 1, indicate that most immunization procedures provoked significant antibody response in the majority of subjects. As seen in table 2, the CF antibody response was also high with all modes of immunization. We have no explanation for the relatively low HI antibody response in the group receiving two intradermal injections 10 days apart, as 71 per cent of these subjects had significant CF antibody rises.

Not shown in tabular form are serological studies of Jamaican children receiving single intradermal dosages of 40 CCA. Determinations of antibodies (HI only) in this group were made in Jamaica, using the method recommended by the Influenza Information Center, United States Public Health Service. Of 16 children vaccinated, 15 had significant antibody rises. Postimmunization sera of all positive reactors had titers of at least 1:40, and six had titers of 1:160 or greater.

Figure 1 compares the percentage of children showing HI antibody rises with that of adults responding to similar immunization routes and

Table 2. — Serological Response of Children to Asian Influenza Vaccine as Measured by CF Test

Initial Immunization	Booster (20 CCA)	Number Tested	Serum	Distribution of Titers*				Net Response**		
				Neg-5	10-20	40-80	160 or Greater	Number Positive	Number Partial	Number Negative
Intradermal 20 CCA	None	119	S1	103	12	4		88	10	21
			S2	24	62	31	1			
	10 days	24	S1	22	2			17	4	4
			S2	5	12	7				
	4½-6 wks.	25	S1	23	2			18	3	4
			S2	5	12	8				
Subcutaneous 100 CCA	None	12	S1	12				12	0	0
			S2	1	5	6				
	10 days	10	S1	10				10	0	0
			S2	1	5	4				

* Titers expressed as reciprocal of initial serum dilution.
** Positive response = fourfold or greater rise in titer.
Partial response = only twofold rise in titer.
Negative response = no rise in titer.
S1 = Preimmunization sera.
S2 = Sera obtained 3 to 8 weeks after final immunization.

Table 3. — HI Antibody Response of Children to Late Booster Inoculation With Influenza Vaccine Preparations

ID Inoculum	Number Tested	Serum	Distribution of Titers*				Net Response**		
			Neg-5	10-20	40-80	160 cr Greater	Number Positive	Number Partial	Number Negative
Monovalent Asian 40 CCA	9	S1	1	6	2		9	0	0
		S2	0	0	1	8			
Polyvalent with 40 CCA Asian	21	S1	0	13	8		16	1	4
		S2	0	2	5	14			
Polyvalent without Asian 20 CCA	8	S1	0	4	4		0	4	4
		S2	0	2	5	1			
None	7	S1	0	4	3		0	1	6
		S2	0	4	3				

* Titers expressed as reciprocal of initial serum dilution.
** Positive response = fourfold or greater rise in titer.
Partial response = only twofold rise in titer.
Negative response = no rise in titer.
S1 = Prebooster sera
S2 = Sera obtained 2 weeks after booster immunization.

dosages. It is seen that both age groups generally had very good responses to the vaccine, regardless of the immunization procedure. Two exceptions were adults receiving a single intradermal vaccination and children having two intradermal inoculations given 10 days apart. More important is the fact that in both age groups the response to intradermal immunization with a four and one-half to six week booster inoculation was equivalent to that of a single large subcutaneous vaccination.

The majority of the children were closely observed following vaccination, and no untoward reactions were noted. This is important inasmuch as many of the children under study suffered from pre-existing conditions in which the slightest provocation may cause severe systemic reactions with marked elevations of temperature.

A group of children was reinoculated four months after primary immunization. The booster inoculations were made intradermally and consisted of 40 CCA of Asian influenza virus as was contained in monovalent or polyvalent prepara-

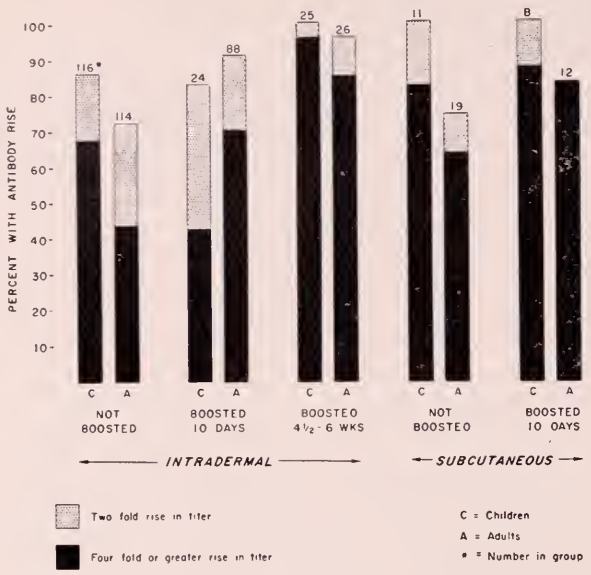

Fig. 1. — Comparative responses of children and adults to immunization with Asian influenza vaccine as measured by the HI test.

tions, or of polyvalent influenza vaccine lacking the Asian strain. Blood specimens were obtained immediately before vaccination and two weeks thereafter. Results of assays for HI antibodies are shown in table 3. It is seen that 100 per cent of the children had a further fourfold or greater increase in HI antibody titer following administration of monovalent vaccine; 76 per cent responded in this manner to the polyvalent preparation containing the Asian component. (The positive CF responses to the monovalent and polyvalent preparations were 89 per cent and 48 per cent respectively). Booster inoculation with vaccine lacking the Asian strain produced no significant antibody responses. It should be mentioned that antibody response to "late" booster vaccination was also observed in adults, but was of a lower magnitude than that in the pediatric group.

Discussion

The results of this study indicate that immunization with Asian influenza vaccine elicited significant antibody responses in children and adults, even when small intradermal dosages were employed. The frequency of serological response to primary vaccination appeared to be related to the immunization dosage, especially as measured by the HI test, but two intradermal injections of 20 CCA each given at four and one-half to six week intervals increased the antibody response to a level approximating that attained by a single large dose given subcutaneously.

Subsequent to the initiation of this project, a number of investigators have reported studies on responses to Asian influenza vaccine. Our findings that single small intradermal doses of vaccine elicit significant antibody formation in both children and adults, and that antibody response is further enhanced by a second inoculation given four and one-half to six weeks later, are in general agreement with and supplement or extend the report of Hilleman and his associates,[3] Rendtorff, Walker, Rowland and Packer,[4] and McCarroll and Kilbourne.[5] They contrast sharply with the findings of Davenport[6] that subcutaneous vaccination with 250 CCA elicited antibody responses in only three of 25 children and two of 23 young adults. Also in contrast is the conclusion of Boger and Liu[7] that 20 CCA given intradermally is inadequate antigenic stimulus for adults.

Evaluation of the protective effect of vaccination with Asian influenza has been made by others[8] and was not the purpose of this study. It should be noted, however, that close clinical observations of residents of homes and institutions included in the program failed to reveal evidence of influenza infections during the study period. During this time Asian influenza was present in the general population, as established by clinical diagnoses and confirmed by virus isolations and serological tests in this laboratory. Such confirmed infections occurred in several boarding schools and public schools in which group vaccination was not undertaken.

One of the participating homes for children reported a prolonged episode of respiratory and gastrointestinal illnesses occurring several months after immunization, and subsequent serological studies were suggestive of Asian influenza infection in some of these cases. It is to be noted that this group of children had not received booster inoculations. Such inoculations may possibly extend the duration of immunity.

It is thought that the smaller initial intradermal dose of vaccine, preferably followed by a booster inoculation, is justified: (1) when the vaccine supply is short and the need is for immunization of large numbers of people; (2) in industrial groups where the aim is prevention of loss of man hours, and where one wishes to avoid absenteeism due to systemic reactions which may be encountered with some lots of vaccine given subcutaneously; and (3) when dealing with persons whose pre-existing condition may make

them more vulnerable to reactions following vaccination.

Summary

The results reported here indicate that even a small amount of Asian influenza vaccine (20 CCA) given intradermally will evoke antibody response in children and in young and middle-aged adults, though optimal responses require larger doses of vaccine or repeat injections after a period of four and one-half to six weeks.

Part of this work was supported by contract with the Communicable Disease Center, United States Public Health Service. The aid of Parke, Davis & Company and Eli Lilly & Company is also acknowledged.

For their clinical and technical assistance, we are indebted to Dr. M. Eugene Flipse, M. C. Launer, R. V. Cating, R. B. Shouger, F. O. Colwell, and P. T. Wellham.

We also wish to thank the Directors and Staffs of Miami Military Academy, Haven School and the Dade County Welfare Department for their cooperation.

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University of Miami School of Medicine.

Volume XLVI
Number 11

Group Practice

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It is a pleasure to be here today to discuss the subject of Group Practice. It has been some 26 years since I enjoyed your very enviable status —that of a Senior in Medical School; yet I can recall most clearly that I was then entirely engrossed in the quest for sufficient scientific data and professional competence to qualify myself as a Physician, and—most important—to pass my examinations and graduate. I am sure that these, too, are your most urgent aims. Yet I would discuss with you this morning something entirely separate from this academic question; and assuming, for the moment, your professional competence—your outstanding medical acumen and sagacity—about which surely there can be doubt, I would direct your thoughts toward the manner in which you will in the future employ these talents, the way in which you will carry out and implement your service to mankind.

Certainly this subject of how and where you will practice is one which is very definitely secondary to that of attaining your maximum professional competence and ability. Yet, from a practical standpoint, the two problems are often interrelated in the over-all picture by which your total effectiveness toward your patient must finally be judged. So I would ask you to examine with me one of the various methods by which you may carry out this service to the public. Think on it, explore its possibilities, and compare it with the other forms of practice, weighing them all carefully; and then make the decision by which your future course will be guided. Fortunately, we are all individuals, and what is good for one is not, of necessity, good for another. You who sit here before me today will become many types of Physicians, embracing perhaps most of the medical specialties as well as the fine body of general practitioners. You will set different goals through which you will carry out your dedicated purpose and toward them you will strive throughout your life. Some of you will practice by yourselves—some with large groups—some in teaching institutions—some in research laboratories. All of you will make your own contribution in your own individual way, the way that seems right to you and the way in which you feel that you can do the most good for the most peope in this, the greatest profession of all.

What I am about to tell you are personal observations, made over a period of a good many years, with one type of medical practice—group practice. I have engaged in it all my medical life, and will describe for you the way that it has related to, and affected me, in my practice.

Group Practice Defined

First of all, what is group practice? Dr. Edwin Jordan has called it *a way of life,* and it seems to me that this is a fundamental and basic concept. Certainly it is more than an arrangement for the convenience of Physicians to practice in pleasant and well equipped surroundings. It is more than an economic device to achieve security, stability and evenness of income over one's productive period, although it provides, to an extent, all of these things. Properly conceived, and properly implemented, group practice is, to me, one means by which several Physicians can combine their skills—their talents—to provide their patients with better medical care. It is a way of practice in which one subscribes to the principle "No One Of Us Is As Smart As All Of Us," and it is a way of practice which, if it is to be successful, can have but one guiding light, that is, rendering better service to the patient. Let me hasten to say that it is not the only way to practice excellent, effective, ethical, honest and economically successful Medicine—it is simply *one* way of accomplishing it. It is fraught with hazards, as are other methods of practice, and it is no panacea for the problems of the sons of Hippocrates, but it can be a most satisfying, enjoyable and rewarding way of practicing Medicine.

History of Group Practice

Let us look back upon the history of the development of this type of practice. It evolved in a nebulous and shadowy fashion—in a spontaneous manner, little controlled by the participants. Certainly the dominant force—the basic principle

Address to Senior Medical Students, University of Miami School of Medicine, Miami, March 10, 1960.

The author wishes to acknowledge that he has borrowed heavily and at times literally from Dr. Jordan's excellent book "The Physician and Group Practice."

—which led Physicians to group themselves together for the practice of Medicine was the advent of specialization which, in turn, resulted from the sheer magnitude and complexity of technological and scientific knowledge. The accumulation of mountains of specialized data and medical information obviously unassimilable by any one individual led to the development of departmentalization of Medicine. With the advent of such specialization, there came inevitably the feeling of insufficiency on the part of the specialist who, while proficient in his own field, was often woefully ignorant in other areas of his professional knowledge. Consequently, he could not provide full medical service by himself, and must seek a practical method of furnishing it. Group practice is one answer, or one suggested solution, to this problem.

Let me be more specific. Following the discoveries of Lister and Morton in the fields of antisepsis and anesthesia, definitive surgery mushroomed into being, and there spontaneously erupted over the surface of the world heroic figures in the field of surgery—men who speedily gained rather vast experience in particular techniques and procedures, and who, by the very weight of numbers of the specialized problems which descended upon them, were forced to limit the field of their activity to the performance of those particular procedures which they could do best and through which they could contribute most to the advancement of Medicine. These surgeons soon realized the necessity, as well as the desirability, of surrounding themselves with a group of assistants, students and technical experts in other fields, particularly diagnosticians, pathologists, and those interested in the medical aspects of their cases. These men, in their turn, became outstanding, well known and famous, and were soon overburdened with an abundance of patients of their own. It became necessary for them to limit their practice, and in doing so they again often chose to limit it to the specialty in which they were the most interested and the most adept. This, then, led to greater specialization, the accumulation of more knowledge and the compounding of the original problem. At about this point, American Medical Schools—particularly the Johns Hopkins University—began to function as a clinical unit, welding the various outstanding men on their faculties into a team of Physicians. These faculty members practiced together, often with economic unity, and were the beginnings of true group practice.

Every discussion of group practice must, of course, include a look at the Mayo Clinic. This again was a natural, a spontaneous type of development, for which Dr. Will Mayo often disclaimed any conscious credit. In 1883, Dr. Will joined his father in the practice of Medicine in Rochester, Minnesota. Later his brother Charles joined them. In the next few years, Dr. Graham, Dr. Judd and a few others, were added to the staff, and finally, the famous and fabulous Dr. Henry Plummer, the internist whose work on the use of iodine in hyperthyroidism revolutionized the management of this condition and made possible successful thyroid surgery. Certainly, with his advent, the organization became a true clinic or group. You are familiar with its later development and the gigantic proportions which it has now assumed in becoming the best known and largest private clinic in the world. It began, however, as a practical answer to the question of providing adequate, readily available, medical care of the first order, to a vast prairie area in the Northwest and then continued to grow because there was constantly emphasized by the brothers the importance of this, their mission, and because of the rigidity and ingenuity with which they developed and utilized the necessary organizational facilities.

Later in this century many other groups were founded, many of them by former Fellows at the Mayo Clinic. During the decade of the '20s, variations of this group practice began to appear. These variations were of two chief types:

First, there was the professional type in which single specialty groups and groups doing only diagnostic surveys were formed. In many instances, these have become outstanding and successful clinics. They have, however, usually been confined to the more populated centers.

Second, an experimental and evolutionary change based on a purely economic approach developed. This type of group practice has been widely discussed, maligned, criticized; and full consideration of it would take hours, if not days. It is an attempt to solve the medical care problem on the basis of prepayment or insurance, with a closed panel type of practice, and involves many types of clinics all the way from County Medical Society prepayment groups to medical units of large Labor organizations, the Kaiser-Permanenti plans, H.I.P. of New York, and others. We will not discuss these in detail, since I have neither the time nor the qualifications.

Group practice has grown, and indications are that it will continue to grow. It has grown in spite of opposition based on honest disagreement with the principles involved, by conservative persons who have thought that any change in the traditional pattern of practice is unwise. Still others have believed that development of groups constitutes an opening wedge for social or state medicine. On the other side of the picture, many Physicians are of the opinion that it is a great bulwark against governmental control. Certainly it is evident that groups must, of necessity, have some regimentation—some rules and some direction. This, it has been argued, is an assault upon our basic freedom. Be that as it may, group practice is almost entirely a North American phenomenon, and one which is growing rapidly. Again, when one looks carefully at its history, one is impressed once more that the groups which have been successful have been those in which the patient's welfare has been the sole or the major motivation. Conversely, those groups in which economic expediency has been paramount have almost inevitably failed.

Attributes Essential to Successful Group Practice

Now let us look a little more closely at the structure of group practice. It involves an association of individual Physicians who are interested in practicing Medicine as a cooperative effort, and who have the sincere conviction that, in this manner, better medical practice can be accorded the patient. They must believe this wholeheartedly and be willing to accept such inconvenience and disadvantages as may arise, in order to enjoy the accumulative experience and wisdom. As I have said, this is a natural outgrowth of the development of specialization and the enlarging vistas of medical information and education, and to those physicians involved in it, it provides an ideal matrix in which the finest web of medical care may be spun. It is based upon mutual help —upon mutual assistance—and upon mutual improvement by the Physicians who take part in it; and it gives one a feeling of security—not financial security, but the security of having readily available the best possible professional opinions, information and procedures.

We are in an age which is materialistic and utilitarian; yet, as you grow older, you will discover—if, indeed, you have not already—that lasting values and worth while accomplishments are almost invariably the result of sound moral, ethical and philosophical precepts. I would, therefore, say to you again that this type of practice will be successful only when its goal is the provision of the finest possible medical care. Certainly it is not the only way to practice—not the only *right* way—not the only *successful* way—not the only *pleasant* way. And certainly it is not for everyone. Is it for you? You alone can decide. To help you in this decision let us outline what it takes to be a successful and a functionally important member of a group. The personal characteristics desirable for the participant in group practice involve human factors and intercourse. They are most important.

First of all—very obviously—one must have professional competence and outstanding ability in some specialized field of Medicine, or, in some groups, in general practice.

Second, one must have a dedication to the practice of Medicine—to the ethics and ideals which have traditionally been a part of our profession. It may be possible to survive without this by oneself. It is virtually impossible to do so in a group.

Third, one must have a certain amount of idealism; and whether or not his feet are firmly planted on the ground, his head should be at least a little bit in the clouds. This is a tremendous help in group practice.

Fourth is the possession of the personality, the type of mind which tends to work well with others, which does not easily take umbrage at criticism.

Fifth is that willingness to give and to take criticism without becoming emotionally upset.

Sixth, one must have a relative lack of envy and jealousy, both professional and economic, and the ability to bear the triumphs and the success of one's partners without any trace of bitterness.

Seventh, one must be imbued with altruism—with a team spirit, or what you will—in which the group is always placed above oneself in approaching the problems which beset it; the ability to compromise—to accept the decision of the majority and to proceed on this decision in a satisfied and cooperative, industrious manner.

Eighth, one must have a generous and lavish supply of loyalty. One must accept the fact that he will rise and fall with the group, and that he must be loyal to it and to its individual members.

Ninth, one must have a maturity in his relationship with his partners in particular, and with

people in general. One must have that ability to keep himself humble and objective—for certainly in a group one is subject to having his professional balloon punctured by his colleagues, periodically; to having his conclusions and opinions proved wrong, and to being subject to that same stimulating, but humbling, procedure which you gentlemen undergo every day in your Medical School life—being reminded constantly of how little we know and how much we *assume* in the practice of Medicine, and that we are, after all, very indifferent scholars of the vast mysteries of life and of disease. Strangely enough, when we leave Medical School, there is a tendency to forget this. There is a tendency on the part of the patient to make us feel all-wise and all-important. There is a tendency to shroud us and our actions with infallibility and with omnipotence—and if we are not careful, we come, over the period of years, to believe that at least a certain portion of this is true—and is justified. This is a dangerous state. Fortunately, it is a state that one cannot keep for long, either in the atmosphere of a Medical School or a medical group. So, if one is not willing to accept the tarnish on the idol—the references to the feet of clay—and the daily reminders of ones' mistakes and failures, as well as ones' successes, one would, I believe, do better to go it alone.

These are the qualifications, it seems to me, that it takes to make a successful member of group practice—a group practice which can offer the patient, first of all, the assurance of around-the-clock coverage in which a Physician with specialty training is always available; in which the records are consolidated, and in which there is, of necessity, a more efficient accomplishment of proper medical care, usually more economically for the patient.

Advantages and Disadvantages

What are the advantages to the Physician in this type of practice? It affords him the opportunity to practice the specialty or subspecialty which interests him most and at which he is most adept—and through which he feels he can be of the most service to his patient. It gives him the opportunity to improve himself by attending medical meetings without leaving his patients in indifferent or less responsible hands, and to improve himself daily through constant exchange of ideas with his partners. It offers him and his patient the facility of free, informal consultation with specialists in other fields. It provides better coverage and greater reassurance. It can furnish a retirement plan and some degree of future security; and to many it represents an ideal way of employing their talents as a Doctor and a servant of humanity.

But it has disadvantages, as well. Amongst these are, first of all, relinquishing a measure of independence—a measure of freedom—which is an essential part of joining any group or any organization. This is true of getting married, joining the Church, joining a lodge, or being a part of the city or state government. And this must be well understood before one accepts the enticing advantages of a medical group.

A second disadvantage is that, as a member of a partnership or a group, one is held responsible, to an extent at least, for the acts of one's partners, and one must have confidence in them, as well as loyalty to them. A third consideration is that the fantastically high incomes which some individual practitioners are able to attain are definitely excluded from any type of group practice, since here income is divided in a more equal manner.

A fourth disadvantage—if one may term it that—is the necessity of abiding by the decision of the majority. This pertains to any sort of group endeavor; and certain rugged individualists may feel that it produces inequities and unpleasant restrictions ungraciously accepted. Finally, a group, if improperly established and guided, may suddenly explode and dissolve, leaving its members to re-establish a different type of practice or seek entry into another group.

All these are disadvantages and are of greater or less significance depending upon the individual personality of the practitioner. But this attempt at unity and confederacy is a peculiarly American device—a device which is still in its infancy and which has a long way to go in the evolution of its final development. Its future holds many promises—and many hazards. To me, it is a method or format within which we may approach the revolutionary changing demands which are placed upon Medicine by today's society, and it offers an opportunity to solve successfully some of these tangled and difficult problems in a convenient, flexible and efficient manner.

Types of Group Structure

So far we have spoken of group practice, and of groups themselves, in a very general way. Let us, for the moment, be somewhat more specific in

regarding this cooperative venture into the practice of Medicine, whose amazing growth in the past 15 years would tend to indicate that it may be the Medicine of the future. Groups vary widely in structure, but all retain the same underlying philosophy. They range from small partnerships to large Foundation Clinics, and fall generally into these categories:

First, there is the private multiple specialty group, which, for the purpose of discussion, may be considered as any group of five or more full time Physicians associated together in practice for the purpose of providing general medical care. Such a group usually includes a specialist in Internal Medicine, as well as one in General Surgery, besides practitioners in at least two or three other major medical specialties, and ordinarily maintains a separate group of offices conducting its practice as an economic unit. This is the basic structure of most groups or clinics and the one with which, I believe, all of you are familiar. It has as its fundamental philosophy the idea that a patient can, within the group itself, find competent, specialized medical care, both diagnostic and therapeutic, and that he can secure from the group operation necessary laboratory, x-ray and other ancillary services. This type of group practice is mentioned first because it is the most rapidly growing form, and at present is the most widespread and familiar. It is not, by any means, the only type which can render excellent medical service.

The second type of group is the general practice group which includes physicians engaged in general practice, banded together for the advantages to be derived from close association, physically, professionally and economically. In this manner, general practitioners can cover each other more readily, can reduce their overhead, and can increase the efficiency of their individual operations, although perhaps not to the extent seen in some other group enterprises. Cross references and some other mutual advantages are perhaps not as well marked here as in the specialty groups; yet freedom for meetings, vacations, postgraduate studies—as well as periodic freedom from week-end, night calls, et cetera—gives the Physician definite advantages. The advantage to the patient stems from the fact that it provides around-the-clock service and Physician-availability through an on-call arrangement.

A third type of group, more common perhaps than the strictly general practice group, is what may be called a mixed practice group in which several general practitioners are associated with physicians practicing certain of the major medical specialties. This is a transition between the specialty group and the general practice group, and is a relatively common form of group practice in the United States. The patient benefits economically from such a group, in that his general practitioner and his specialist are combined in a single organization which can take care of him for a somewhat smaller total fee than would be customary if the two physicians were seen and consulted separately. In general, the advantages and disadvantages are the same as those found in other types of group practices. Here, also, those physicians who command extremely large fees, simply by virtue of the nature of their work, must be willing to sacrifice something insofar as their individual income is concerned, in order to provide a more equitable basis for the partnership. This is so primarily because the disparity of fees in the various specialties is more readily accepted by the patient than by the Physician.

Such organizations will vary a great deal in size and will be limited by the population and the economy of the area served. It is important in groups of this type that the specialist be willing to take his turn as a stand-in general practitioner if rotation of night and week-end calls is to be successful, unless the organization is large enough to provide an on-call man in each special department. Again, if each member of the organization is willing to work unselfishly for the benefit of all, this will result in an entirely satisfactory professional cooperative enterprise, lessening the pressure on each member, dividing the responsibility, and ensuring, to some degree, economic security.

An additional type of group practice is that represented by the single specialty group. This usually ensues when an older Physician, already established in the practice of a specialty, takes one or more partners. It is probably as old as specialization itself; and recently various specialists have formed much larger single specialty organizations. The reasons for establishing such entities are: producing more constant, around-the-clock service for the patient, rotation of calls, opportunity to attend medical meetings and postgraduate courses, and establishment of some leisure time for the Physician. Obviously, such group practice can survive only in an area adequate to support a large specialty practice. Al-

most invariably these groups are smaller, in the number of Physicians involved, than the multiple specialty organizations. Structurally, they are either a single proprietorship or a partnership. In looking ahead, one might prognosticate that their future will be confined to extremely heavily populated areas, and that they will disappear in the smaller localities with the development of multiple specialty organizations.

In addition to those already named, there is still another type of group which is represented by a relatively few clinics in this country. This is the medical diagnostic group, a clinic established solely for the purpose of diagnosis and periodic prophylactic examinations, as well as general health counseling. Such groups obviously have a limited type of personnel, chiefly internists, a pathologist and a roentgenologist, as well as available laboratory facilities. They are not concerned in any way with the therapeutics of Medicine, confining their efforts simply to diagnostic procedures. Obviously, there is difficulty in following the progress of patients, since they do not return for therapy. Such groups must be willing to forego the satisfaction that stems from observing patients' progress under properly applied therapy. As a corollary, however, they are spared the miserable failures which we often see culminate our most sincere and honest efforts. If the thrill of cure is denied to these physicians, so is the discouragement of failure and of death.

The Medical School group, of course, forms yet another organization of clinicians practicing Medicine in a cooperative manner. As a rule, these physicians are full time faculty members who combine the training and teaching of medical students with the opportunity for clinical practice. Such a group will appeal to the physician who is academically inclined, who wishes to continue with a certain amount of research, and who is willing unselfishly to devote a good portion of his time to the teaching and training of new Physicians. This was perhaps the first type of clinic practice and has changed less than any other. You are all familiar with it, I am sure. The economics and finances of such a group are usually handled by a business manager who is part of the University structure, and usually the Chairmen of Departments compose the executive committee or board of directors. Such a Medical School clinic allows the School to have excellent teaching at a minimum cost and provides the hospital with a competent staff in all fields to look after both private and charity patients. Reduction in income is compensated for by the help of several assistants, the opportunity to carry on research projects and the prestige of being associated with the faculty of a teaching institution.

Finally, there is a form of medical group—the so-called Hospital Group—which is not, in general, a closely knit group insofar as outpatient care is concerned, but which consists in the banding together of Physicians practicing in one hospital for cross referrals, et cetera. This is a type of organization which is viewed with some alarm by the practicing Physician, who fears that through it the lay personnel of hospital boards and directors may enter the actual practice of Medicine. More will not be said about it here.

These, then, are the various types of clinics. Let us consider for a moment the obligations peculiar to *all* of them.

In the first place, any clinic has as its serious responsibility the institution of a program to supply comprehensive and effective medical care for the community which it serves—the responsibility for attempting to meet the local socioeconomic requirements and adapting itself to changing requirements. Further, it is the obligation of such a group to supply leadership and guidance in the medical affairs of the community; to participate in public functions, public problems, and public enterprises; to furnish citizenship as well as professional excellence, and to render community, as well as medical, service.

And what are the dangers—or at least *some* of the dangers—of group practice of any sort? Certainly, one must ever be aware of the coldness—the impersonality—the aloofness—which is apt to creep into the organizational practice of Medicine. Patients are not numbers. They are not commodities, nor even laboratory specimens. They are living people with vital personalities and individualities—people in whom we must be personally interested, if we are to serve adequately. Patients will not forget this interest, nor will they forgive us for forgetting it. Certainly, business efficiency and effectiveness cannot be disregarded, but neither must we allow ourselves to be cold, impersonal or unsympathetic in our manner. This is an ever present danger which can be conquered by personal interest, just as in individual private practice, if we remain mindful of its importance.

Now let us look at the types of clinics categorized by internal structure. They are six.

Partnership

The first, and perhaps the simplest, type of group practice, is the partnership. Legally, this is the same as single ownership, and is simply the banding together of several owners for a joint operation. The partnership as such does not pay an income tax, but all profits are distributed to the individual partners, and each pays tax on that portion which accrues to him. The partnership, however, must file an income tax report, for information purposes. Although the rights and duties of the individual partners are outlined in a legal agreement, each partner is liable for the acts of the remaining partners, in anything which affects the partnership or its business. The partners may be all full partners, with equal privileges, or there may be junior and senior partners whose privileges are spelled out in the agreement.

This partnership may own its own building, instruments, furnishings, et cetera, or these may be owned by an affilated corporation from which the partnership rents space. Usually the partnership owns the accounts receivable, and most often, the supplies, medications, et cetera. As a rule, it also employs the personnel required to operate the Clinic. All partnership agreements should be in writing, not only for the sake of clarity, but to prevent misunderstanding and differences of opinion as to what the original agreements were. A partnership is a serious undertaking. It is a banding together of physicians for a common purpose—a common casting of lots—an entrance into an agreement which is presumed to last throughout one's professional life. It is, in a very real sense, similar to the contract of matrimony. It requires give-and-take; it requires compromise and tolerance, as well as respect for another's feelings and opinions.

In Clinic practice, partnership agreements usually provide that all partners will devote their full time to the practice of Medicine, turning over all their income from this practice to the partnership itself. In the distribution of profits, usually the length of time with the group, the productivity of the individual member, his prestige and ability to attract patients are all made part of a basic formula. In addition, an adequate partnership agreement provides for death, retirement, withdrawal—even expulsion—of partners, as well as for mutual liability and at times deferred income benefits. A partnership agreement has the advantage of simplicity and flexibility. It is, indeed, a form of democracy with which we are all familiar in one way or another. It is an ideal structure for the easy solution of problems and controversies. It requires, of course, a capital investment on the part of each of the partners, with the younger partners usually providing this, little by little, over the years.

This capital account represents a valuable savings program available to the member when he retires from the partnership and ceases to practice Medicine. Often, particularly to the young man out of his training program, the question of buying into a partnership raises a dread and awesome specter that forms a large and discouraging cloud over an otherwise desirable association. The young man in this position hesitates—and understandably so—to obligate himself for a seemingly huge investment over a period of many years. Let me assure you that this is an ephemeral and ghostly demon, rather than a real one. The money invested in a sound partnership is the wisest money that a young man can spend. It will force him to embark upon a savings program which will undoubtedly be his chief source of future retirement and financial stability. Unless he is an exceptional person, his tendency will be to spend or commit most of the revenue which comes his way, and this enforced investment program will be beneficial to him. To most, it will also give the sense of satisfaction that comes with ownership. It will help one's morale and one's sense of position and stability.

Departmentalized Partnership

The second type of group is the departmentalized partnership, in which the same basic organization obtains as in the general partnership, but in which each specialty constitutes a small partnership by itself, running its own department, sharing its own net income and cooperating with the other departments to form a larger over-all partnership. This type of organization seems to effect closer unity within the departments, but less unity between the members of the clinic as a whole. It also, it seems to me, tends to foster intraclinic competition and more imperfect communication, since it lacks a central governing body with authority. Nonetheless, this is a practicable and workable type of group practice that has been successful.

Association

The third form of group practice is an association. Recently this has enjoyed a considerable

amount of favorable interest amongst all organizations, since, particularly in the larger groups, it has some tax advantages. Briefly, an association is a partnership which is taxed as a corporation. It is, indeed, an unincorporated corporation, or a corporation solely for tax purposes. This status allows it to set aside funds for a retirement program for the individual members, and to set these funds aside without taxes, until the money is drawn by the individual member. It has many seeming advantages, the bulk of which tend to disappear for most Clinics on careful scrutiny. The establishment of a retirement program, however, is definitely aided by this type of setup. Again, the formation of an association almost always necessitates a dual type of organization: first, the association which conducts the practice of Medicine; and second, the corporation which owns the building and the equipment, and from which the association rents space. In this form of operation, the association itself has no ownership of any of the physical assets, and an associate, upon death, resignation or retirement, does not disturb the continuity of the organization; whereas, in a partnership, of course, dissolution and reformation automatically take place upon the withdrawal of a member. Practically, this latter presents no difficulty.

In an association there is, of course, an employer-employee relationship. Social Security is paid, and its benefits are available to the members. The association is run by an elected board of directors or board of governors, and the necessity for "buying in" is largely eliminated. Taxwise, it may, in an individual case, present a definite advantage, or a definite disadvantage, and it is of the utmost importance that a very competent tax attorney and a competent accountant be consulted as to the exact type of structure most beneficial to any particular group. By and large, the association type of organization is primarily designed for problems of growth and expansion, just as is the next form of organization, the foundation.

Foundation

The foundation operates as a charitable corporation to which monies have been contributed by the founding members and others, and which operates the clinic and the hospital, if there is one, and treats all of the associates as employees. Being a charitable foundation, it can enlarge, grow and function very easily financially, since its funds are nontaxable. In other ways it functions as an association. This is the type of organization of the larger clinics, such as the Mayo Clinic and the Ochsner Clinic, which allows them to use their excess profits for furthering development and growth.

Corporation

Little needs to be said about the fifth type of clinic practice, the corporation. It is illegal in most states, including Florida, for a corporation to practice Medicine; hence, such a corporation is rare. Furthermore, it is generally frowned upon as being unethical, according to the Principles of Medical Ethics as laid down by the Judicial Council of the American Medical Association. The corporation cannot, of course, receive medical training, and since the responsibility of rendering medical service rests upon a person who has such training, it is thought that a corporation itself, or the laymen who may direct it, should not be in a position of rendering this service or of taking the responsibility for delegating it. It is further thought that the corporate practice of Medicine would, and perhaps does, exploit the Physician's services, allowing persons other than Physicians to make a profit from such services. Nonetheless, there are a few group organizations in corporate form. Some of these are in states which permit corporate practice, and some are in the nonprofit foundations which we have just outlined. Actually, there would seem to be few, if any, advantages to this type of structure for you and me as individual Physicians.

Sole Proprietorship

Finally, the sixth form of clinic practice is that of sole proprietorship. This, very simply, is the setup in which a single Physician owns all the assets of the clinic and controls the practice, with his associate Physicians being employees and receiving their remuneration on a fixed salary scale or on the basis of a percentage of their production. Many times such an arrangement works extremely well, particularly when the Physician who starts it is a wise, generous and farsighted person. Many more complete types of group practice have resulted from beginnings in a sole proprietorship type of arrangement. Obviously, however, since this depends upon a single person, every sole proprietorship clinic has a limited existence.

These, then, are the types of clinic arrangements which you may look for should you decide

that you wish to spend the rest of your medical life practicing with a group of other similarly motivated Physicians.

Business Management

Now, just a word about the business management of group practice—what you might expect if you join a group, as opposed to practicing Medicine by yourself. In the first place, you will be involved in a much larger financial venture than that of a single Physician's practice. There will be buldings, equipment, libraries, leases, and a thousand and one other things. There will be large numbers of medical and paramedical personnel who will work with and for you; and they will be under the direction of a Clinic Manager, if you join an adequately functioning group. It is essential that such a person, particularly trained in this field of endeavor, handle the many complex problems relating to the things that I have mentioned, as well as the legal problems, the tax problems, the insurance work and the personnel problems. Indeed, it is for this very reason that many of us are inclined to favor a clinic type of practice. It puts this business or administrative work in the hands of someone who is trained to handle it, and relieves us of this responsibility, so that we can devote our time to the practice of Medicine.

The operation of the average clinic is a business in itself, and a very difficult one at times. The supervision of a laboratory—an x-ray department—a library—a pharmacy—a physical therapy department—and the many other integral parts of a well established clinic demands considerable time, acumen and experience. There is also involved, initially, a large overhead, and from a practical standpoint, in the average-sized group, this means that you and I, as individual Physicians, will have more facilities at our command than we would if we were in private practice and will operate them somewhat more economically than would be possible alone, but since we have more of them available, we will wind up with about the same percentage of our income in overhead as if we were practicing by ourselves. This is true if we are within a moderate range of income in solo practice. It is not true if we are in that extremely high bracket which some surgical specialties command.

The Choice

Basically, it means this: If you choose to practice in a group, you can have these additional facilities available at no increased expense, from the financial standpoint, but you will have to make those sacrifices which one must always make when one joins any organization.

Carefully examine these advantages in any group that you may contemplate joining. Assess the value of available consultation with members of that particular group—the advantages of working with them—the completeness of available facilities—the opportunity of pooling your medical knowledge and education, through your daily contact with these men; and then ask yourself if the sacrifices which you must make are really worth it. Ask yourself, indeed, if the price is right. For group practice, whatever form it may take, has much to offer; and like anything that is worth while, its demands are also considerable.

I have tried to spell out for you some of the forms of group practice, as well as some of the pros and the cons of this manner of practicing Medicine. It is a compelx—a young—a flexible—and at times a complicated effort to solve the very difficult and diverse problems that face us in the practice of Medicine today as they have never before. Too long we have been bound by the past, by tradition and by the rigid rules of our glorious heritage as Physicians. Certainly we must keep these rules, these traditions; yet we must adopt an inquiring and flexible attitude in dealing with them, for we have today social problems which were unknown to yesterday's Physicians. We have today a challenge which extends far beyond that of providing technical knowledge and care. We have the problem of making available the very best medical information—the best diagnostic and therapeutic procedures—to all of the people in this complex society of ours. We must do so on an economic scale which is sound, from the Physician's standpoint, and which will be practically available, from the recipient's.

This is a large order. It will require all of our ingenuity and ability. Many of us think that it may be best met through clinic type of practice, and that the future of modern Medicine lies in this type of group effort.

I urge you to give your attention to this matter—to ponder it and to inquire into all its vagaries—to inform yourself to the best of your ability—before you make your final decision as to the type of practice in which you, individually, wish to spend the remainder of your medical life. Should this be group practice, remember this, and use it as a yardstick in measuring any group

which you may contemplate joining: The success or failure of your group will, in the long run, depend, inevitably, on the underlying principle which motivates it. If this be the better practice of Medicine—the better care of the patient—the group *must* be a success; if it be merely economic expediency, the group must just as surely fail.
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Diabetes Case Finding Among Relatives of Indigent Diabetics in Florida

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A diabetes case-finding project among relatives of indigent diabetics in Florida began during the latter part of 1957. Up until that time the diabetes screening program was operated in connection with the serology surveys, which were conducted by the Venereal Disease Division. With the termination of the serology surveys, however, other ways of finding Florida's unknown diabetics had to be found.

Studies have indicated that relatives of diabetics have a higher incidence of unknown diabetes than do nonrelatives. Florida, being fortunate enough to have at its disposal names of approximately 2,700 diabetics on its insulin rolls, decided to initiate a case-finding program among relatives of these diabetics. Methods, procedures and personnel requirements had to be worked out. Consequently, a health field worker was employed by the Chronic Disease Division to assist in the formation and carrying out of a diabetes detection program. Inasmuch as funds were limited, it was not possible to provide for any large scale type of testing program, such as was the policy some years back when a trailer was used and a team of survey personnel accompanied it.

Method

Because of the close relationships that county health departments have with their indigent diabetics, it seemed only logical that a diabetes detection survey among relatives of the indigent diabetics should be a joint program between the State Board of Health and the County Health Departments.

As is the case in other types of surveys, it is necessary to obtain approval from the local medical society before a survey is conducted in a particular area. After the medical society approves a survey for its area, the next step is to obtain names of the relatives of the indigent diabetics. They are obtained by one or all of three methods. The first method is by mailing questionnaires to the diabetics asking them to give us the names of their parents, grandparents, uncles, aunts, siblings, first cousins and children. The second way to obtain names of these relatives is for the diabetics to be interviewed when they report for insulin and the questionnaire filled out at that time. The third way is for health department personnel to visit the diabetics who are not reached by either of these methods.

After names of relatives have been received and tabulated, they are then invited into the health department for a blood sugar determination. A registration form is filled out on each examinee in order to aid in the evaluation of the blood sugar results. Space is provided in the registration form for a complete listing of all food consumed during the last meal, as well as within two hours just prior to the test. This is particularly helpful in cases where the blood sugar level is near the screening level.

When the diabetes detection program among relatives of indigent diabetics was organized, it was decided to test the examinees approximately two hours after they had consumed a meal rich in carbohydrates. Studies have shown that the closer the screening procedures approach the standards of the glucose tolerance test, the more accurate the results will be. For example, if no attention is paid to the length of time between the last meal and actual testing, persons who had their meal three to four hours before may not

Health Field Worker, Florida State Board of Health, Jacksonville.
Read before the Florida Health Officers' Society, Bal Harbour, Miami Beach, May 3, 1959.

have a positive urine nor an elevated blood sugar, even if they have mild diabetes. On the other hand, persons tested one-half hour to one hour after a meal rich in carbohydrates may have a physiologic elevation of blood sugar above the screening level and would give a false positive result. Although these "positive" screenees would turn out to be "negative" at the re-test stage of the detection program, the first screenees, as seemingly "negative," would not reach the re-test stage and therefore would remain undetected diabetics.

The blood sugar screening level is 130 mg. per hundred cubic centimeters by the Wilkerson-Heftmann method. Quantitative tests are performed by the Somogyi-Nelson method.

Usually, approximately 40 to 50 per cent of the relatives named reported to the health departments for a test. In some counties these relatives were visited by the health department personnel in order to (1) offer them a test, and (2) to try to find out why they failed to report for a test. The reasons most frequently given for not reporting were that (1) they had been tested by their private physician, (2) they were working, and (3) they "felt fine and saw no need to be tested."

The method of follow-up has been the most flexible part of this program. For one thing, in a selective survey of this type, one does not test such large numbers of relatives that the follow-up is a tremendous job. Letters are mailed to all screenees who had normal blood sugar levels, informing them that they have no laboratory evidence of diabetes at this time, but advising them to get a regular diabetes check-up and to know the signs and symptoms of diabetes.

Since the "positive" screenees are so few in numbers, it is usually possible for nurses to visit them and refer them to a doctor or to the health department for a re-test. Whether the suspects are referred to the health department or to their private physician for a test largely depends on the policy of the local health department and the medical society.

It is interesting to note that in a screening program conducted by Petrie and his associates, 1,981 persons with a diabetic type of glucose tolerance test were found.[1] These suspects were referred to their private physicians for re-test. More than 82 per cent of these referred persons were classified as nondiabetic, but their private physicians did no laboratory work at all or only a urinalysis or a fasting blood sugar test. Some authorities agree that these are apparently "unreliable tests" for the proper diagnosis of diabetes mellitus.

On the other hand, when the follow-up studies were performed by the same medical team which did the screening and the diagnostic tests, results seemed much more consistent and in keeping with each other. These observations indicate that results of screening programs could be greatly improved if screening, diagnostic tests, and subsequent studies were performed by the same medical team.

Results

Time does not permit me to present many figures and statistics. Certain figures, however, are important in analyzing the results of a project of this type, particularly if it is to be continued. It is noteworthy that in 1958 diabetes was the seventh leading cause of death in Florida. In

Table 1. — Florida State Board of Health Summary of Diabetes Screening of Indigent Relatives Project December 1, 1957—April 30, 1959

County	Number Blood Specimens	Number Positive	Per Cent Positive	Disposition Unknown	Disposition Known	Not Diabetic	Disposition Pending
Jefferson	7	2	28.60	1	1		
Madison	13	0	0.00				
Marion	14	1	7.14		1		
Putnam	11	1	9.09	1			
Suwannee	18	2	11.10			2	
Taylor	4	0					
Hillsborough	423	22	5.20	11	4	7	
Duval	142	4	2.82	2		2	
Hamilton	10	3	30.00			2	1
Jackson	28	0					
Calhoun	10	0					
Polk	257	4	1.56		1		3
Grand Total	937	39	4.16	15	7	13	4

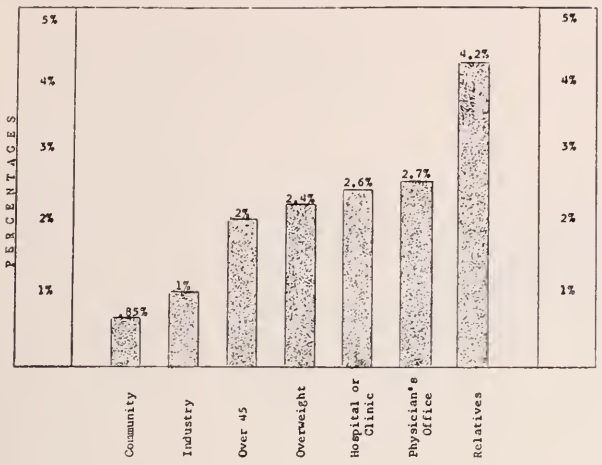

Fig. 1.—This chart gives the percentages of newly discovered diabetics found in various types of screening surveys. Source: U. S. Department of Health, Education, and Welfare, Public Health Service, Bureau of State Services, Division of Special Health Services, Chronic Disease Program.

1957 diabetes was the eighth leading cause of death in Florida. The detailed figures for each county where this program has been carried out, giving the results thus far, are shown in table 1.

As a rule, known diabetics are not tested, but occasionally for some reason, probably the hope that we will tell him he does not have diabetes, a diabetic fails to mention his condition to us. If we had tested all the diabetics who wanted a test, undoubtedly our percentage of positives would be high. I think that an insufficient number of relatives have been tested for us to draw any definite conclusions at this time.

Figure 1 shows a comparison of the results of different types of screening surveys. In order adequately to interpret results of a survey, I believe it is necessary to know many of the procedures and exact methods used. For example, as mentioned earlier, was the follow-up done by the medical team that also did the screening, or were positive screenees referred to their private physicians for diagnosis? Also, what was the screening level, and how close did the screening tests approach the standards of the glucose tolerance test? These are only a few of the factors that influence a survey's results.

I should like to add that any county health officer interested in making a diabetes survey among relatives of indigent diabetics may proceed without waiting for us to contact the County Health Officer. Of course, the Florida State Board of Health will be glad to send him all information, including forms, letters and leaflets, that he may desire.

Reference

1. Chesrow, E. J., and Bleyer, J. M.: Results of Diabetes Detection Drives, With Special Reference to Aged Population, Geriatrics 11:119-126 (March) 1956.

P. O. Box 210.

ABSTRACTS

Recovery of β Hemolytic Streptococci From Throats of Mother and Child: Relationship to Respiratory Illness. By Milton S. Saslaw and Murray M. Streitfeld. J. Infect. Dis. 104:233-237 (May-June) 1959.

The recovery of group A β hemolytic streptococci from the throats of mothers and their children may be an important guide in the epidemiology of streptococcal infection and in the etiology of rheumatic fever. The study here reported was undertaken to determine the relationship of spread of streptococci between mothers and their children in the second grade of school, and how such spread might be correlated with the school absenteeism of the child. Fifty-three children attending public schools in Miami were subjected to weekly throat swabbings and monthly venipunctures during the 1956-1957 school year, and mothers of 36 of these children also participated in the program. The throat cultures were studied for the presence of β hemolytic streptococci. The venous blood samples were submitted to antistreptolysin O titer determinations. The failure to observe frequent transmission of organisms from mother to child or from child to mother led to the conclusion that, in the absence of an epidemic of streptococcal disease, low streptococcal pathogenicity and/or high host resistance may account for the infrequent concomitance of β hemolytic streptococci and clinical respiratory illness in spite of the common recovery of streptococci from children's throats.

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 2411, Jacksonville, for abstracting and publication in The Journal. If you have no extra reprints, please lend us your copy of the journal containing the article.

Leo Michael Wachtel Jr., M.D.
President 1960-1961
Florida Medical Association

THE JOURNAL
OF THE
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Leo Michael Wachtel Jr., M. D., President

A native Georgian, Dr. Leo Michael Wachtel Jr., was born in Savannah on Oct. 5, 1912. He attended local schools and was graduated from the Savannah High School. He entered Emory University in Atlanta for his academic training, where he was elected to membership in Omicron Delta Kappa. In 1934, he was awarded the Bachelor of Arts degree by that institution. He then chose Jefferson Medical College in Philadelphia for his professional education and received the degree of Doctor of Medicine there in 1938. From 1938 to 1940 he served an internship at St. Vincent's Hospital in Jacksonville.

A member of the Army Medical Reserve Corps from 1938 through 1942, Dr. Wachtel served during World War II at Carlisle Medical Barracks, Carlisle, Pa., with the rank of first lieutenant. Upon discharge from military service, he returned to Jacksonville, where he has engaged in the general practice of medicine for nearly two decades. Locally, he is a member of the courtesy staff of Baptist Memorial Hospital, St. Luke's Hospital, Duval Medical Center, Brewster Hospital and Hope Haven Hospital, and of the active staff and chief of the Department of General Practice at St. Vincent's Hospital, where he was president of the staff from 1954 to 1956. He also serves as school physician to St. Vincent's Hospital School of Nursing.

Dr. Wachtel has served Florida medicine with distinction through the years both at the county and the state levels. From 1944 to 1946 he was secretary of the Duval County Medical Society and in 1957 served as its president. From 1944 to 1954 he was a member of its editorial committee. A member of the Council of the Florida Medical Association from 1956 to 1958, he held membership in the Association's Key Contact Committee in 1958 and 1959 and also served as chairman of the Necrology Committee during those years. In 1957, 1958 and 1959 he served on reference committees, the first year as chairman. Active in his chosen field, he was secretary of the Florida Academy of General Practice in 1953 and in 1956 was its president. At the national level, he is presently serving a three year term as a member of the Commission on Hospitals of the American Academy of General Practice.

In addition to holding membership in the Duval County Medical Society, the Florida Medical Association and the Florida Academy of General Practice, Dr. Wachtel also holds membership in the Florida Obstetric and Gynecologic Society. National medical organizations with which he is affiliated include the American Medical Association, Southern Medical Association, American Academy of General Practice and World Medical Association. From 1956 to 1959, he was a member of the board of directors and of the executive committee of Blue Shield of Florida. In 1959 he was chairman of the Jefferson Medical College Alumni of Florida.

From 1942 to 1947, Dr. Wachtel served on the board of directors of the Jacksonville Junior Chamber of Commerce, and during 1945 and 1946 was vice president of the Florida Junior Chamber of Commerce. He is a member of the Riverside Presbyterian Church of Jacksonville, in which he has served as an elder since 1955. He also holds membership in the River Club and serves on the board of trustees of the Bolles School.

Dr. Wachtel and Mrs. Wachtel, the former Miss Helen Ross Dixon of Brunswick, Ga., have two sons, Leo Michael Wachtel III and John Dixon Wachtel.

Modern Thoracic Surgical Management

Aside from the great strides made in operative safety over the past 20 years, many refinements in technique have appeared in the management of disease of the chest.

Bronchoscopy, an almost routine procedure in evaluation of thoracic disease, is now often performed with the patient in the sitting position. Even the patient with the most severe cardiac disease can, if need be, tolerate examination in the sitting position with or without the oxygen attachment on the bronchoscope. Facility without undue manipulation is thus attained, and with the use of the right angle and oblique lenses, all of the major bronchial orifices may be visualized. Selective bronchial washings coupled with special bacteriologic techniques enable precise diagnosis, especially in determining the location of an open draining source of acid-fast infection or primary tumor. Progress has been made in tumor cell identification in the usual bronchial aspirate and also in the collected 24 and 48 hour sputum specimen. As pathologists gain more experience in tumor cytology, a smear of the sputum may become a more useful screening test for cancer of the lung.

Scalene fat pad biopsy is now performed almost routinely in suspect neoplasia of the lungs. As a general rule each lung drains to its corresponding side of the neck, but it has become common knowledge that the right lower lobe may drain to the left side of the neck. The usefulness of this simple procedure is obvious in preventing unnecessary thoracotomy.

Pulmonary function studies presently offer a useful guide in determining how incapacitating surgical removal of pulmonary tissue will be. In borderline cases bronchospirometry coupled with maximum breathing capacity determinations will disclose those patients unable to undergo resection safely.

Detailed preoperative explanation to the patient of the importance of coughing, deep breathing and shoulder motion is another refinement which should be routine in all thoracic procedures. The occurrence of shoulder disability has been all too frequent in the past following procedures such as thoracotomy and radical mastectomy and can be largely prevented by seeking patient cooperation preoperatively and by stressing full range of shoulder motion as a daily exercise postoperatively.

Perfection and dissemination of modern positive pressure equipment coupled with the use of various mucolytic agents facilitate aeration of atelectatic segments in surgical and medical cases.

In certain selected patients, medical hypnosis has been used to enable effective coughing postoperatively, and pain has been decreased by hypnotic suggestion.

In the future, with perfection of heart-lung machines and various prosthetic devices, the scope of thoracic surgery will be widened even further.

William R. Rundles, M.D.

Communication

1. With Patients

Communication has become a highly developed science, reaching as far as outer space, from which electrocardiograms and other biological measurements may be telemetered back to this earth. Upon this planet men may communicate with each other by a host of engineering marvels. Yet despite these advances in methods of communication we of the medical profession have fallen sadly behind in our attempts to, and ability to, communicate with others. Several facets of this problem will be explored in this and succeeding editorials.

Communication is defined as an interchange of thoughts, and as a conference for the joint possession of something intangible such as news, opinions or intelligence. It is above all a *sharing*, with benefits deriving to each participant. It may contribute to "good public relations," but should not be considered synonymous, for public relations is more in the nature of advertising or promoting the good points of a profession or company without interchange of views.

As physicians, our most frequent communication is with patients. Although each of us has developed his own methods of history-taking and of discussing diagnosis and treatment, it is worth reminding ourselves that not all communication is verbal. To the observant physician, the patient may betray many emotions, including anxiety or grief, by his posture, his blushing, the avoidance of certain subjects, or by inappropriate answers. Conversely, the physician, by unguarded shrugs, frowns, and the like, may convey unintended criticism or concern to an overly sensitive patient.

In all discussions between doctor and patient, it is essential that each understand the other. The patient should be asked to explain unfamiliar slang phrases, and should be encouraged to ask for simple definitions of medical terms he does not understand. "Cardiospasm" may be as insignificant as a hiccup to the physician, but unless the term is avoided or is clearly explained as pertaining to the gastrointestinal tract, its use might well convince the patient that he has heart disease. Or consider the plight of the young man seeking a circumcision who expressed himself so poorly that a vasectomy was performed. A few moments spent in defining terms—in true communication—would have prevented such a catastrophe. A blackboard, models or simple pictures will often assure complete understanding of technical terms.

The doctor must also be aware of the adeptness in communication (or lack of it) by the personnel in his office, who are so closely identified with the doctor himself. A cheerful receptionist who greets the patient by name, and the sympathetic nurse who often obtains bits of information not proffered the doctor, can both be assets in promoting adequate communication between doctor and patient.

These may be considered petty points, but unless adequate communication is established between physician and patient, not only is first-rate therapy impossible, but the prestige of the entire medical profession suffers.

J. M. P.

Role of Live Attenuated Poliovirus Vaccine

Although the development of Salk vaccine against poliomyelitis represents one of the great milestones in medical research, the disadvantages of this vaccine have also become apparent with its use.

Its major biological limitation appears to be the fact that although good protection against paralytic disease is conferred upon the individual by a potent vaccine, there is no barrier to the continued transmission of poliovirus through the enteric tract. Among the practical limitations in achieving 100 per cent immunization levels have been the expense, the requirement for repeated injections with a needle, and the difficulties in producing uniformly potent lots of vaccine. The net effect has been that large segments of the population remain susceptible to paralytic disease, and without vigorous efforts to initiate and repeat

vaccination, this susceptible segment is likely to increase.

Live attenuated poliovirus vaccine presently may have the answer to many of the problems involved in the use of killed vaccine. Because it will be far less expensive and because it is administered as a pleasantly flavored drink, it should be far more acceptable to the public. There is also hope that one dose of the new vaccine may be at least as effective as several doses of the highly effective killed vaccine. Both kinds of vaccine provide systemic immunity, but only the live vaccine induces a local tissue immunity that may provide a degree of protection which even several doses of killed vaccine does not provide. This may result in an immunity of the intestinal tract to further infection and dissemination of poliovirus, and probably eliminate the healthy carrier state in polio. The possibility exists that the vaccine virus may completely eliminate the wild and virulent poliomyelitis virus from the community.

The Surgeon General of the Public Health Service has expressed the need for large scale field trials of the live vaccine in this country. There is no question in the minds of practically all authorities that the new vaccine is safe for the person receiving it. A few authorities have indicated concern for the safety of unvaccinated contacts to vaccinated persons. Under the sanitary conditions generally prevalent in this country, however, it is thought that there will be no significant degree of spread of the vaccine to contacts by natural methods. Furthermore, very carefully supervised use of the vaccine on several thousand people in this country has already given convincing proof of the safety of live virus vaccine. There have been no indications that even minor reactions occur. At least 12,000,000 doses of live poliovirus vaccine have already been administered in other countries of the world.

Both small and large scale studies have usually called for the sequential feeding of children of 0 to 12 years of age or less of the three types of attenuated poliovirus, but in some of the most recent studies the simultaneous feeding of all three types has been done with apparent demonstration of triple immunizing capacity. Following the administration of the vaccine there has usually been a surveillance period of several months duration or longer in which both vaccinated persons and their associates have been observed rather closely.

ANTIBODY RESPONSE.—The studies designed to test the efficiency of the vaccine have yielded different results in different environments, varying in children from 50 to 60 per cent effectiveness to as high as 90 to 100 per cent. The antibody response depends on successful establishment of alimentary infection. The response of newborns and children of varying ages and adults including pregnant women have been studied, and in general, infants and children responded better than adults. The immune status of the individual prior to feeding, as well as the dose of the vaccine, obviously had an important bearing on this response.

INTERFERENCE.—Some viruses found in the alimentary tract, as well as poliovirus, may prevent to an extent as yet unknown the infection with attenuated poliovirus from becoming established. Recent studies have indicated that when either a higher dosage of each virus type is used in a trivalent preparation or when the preparation is fed more than once, the results are at least as good or better than those achieved by feeding the strains consecutively.

DISSEMINATION OR CROSS INFECTION. — The degree of spread of infection to contacts of those vaccinated varied considerably in different situations, but in families and in closed institutions spread was common. In countries with a low degree of natural immunity in childhood, considerable spread may occur in the nonvaccinated population. On the other hand, it appears that in communities where immunity is acquired at an early age the spread of the vaccine virus is apparently restricted. It has not been possible to follow clearly the natural spread of attenuated poliovirus after its first or second passage.

SAFETY.—Since the development of these vaccines, each has been widely used under a great variety of circumstances. Studies of great magnitude involving administration of vaccine on a community-wide basis to hundreds of thousands of persons have been reported from Africa, Asia, Europe and Latin America, and two trials involving several millions in the Union of Soviet Socialist Republics. Smaller, and therefore more carefully controllable studies, have been reported from Europe and the United States. The degree of thoroughness with which orally vaccinated persons and their contacts have been observed for evidence of adverse effects has varied greatly in

different studies; yet no evidence has been adduced that use of any of the vaccines has been followed by either paralysis or ill-defined illnesses in either group in a greater number of instances than has been observed in a control group or in the community at large among nonvaccinated persons.

Effectiveness.—Although the studies have uniformly shown significant increases of antibody for all three types of virus and therefore presumed protective value, few of the studies have been conducted under conditions that could possibly shed light on the value of the vaccines in preventing paralysis. This has been due not to defects in the studies but rather to the known low attack rate of paralytic poliomyelitis and the extreme variability in the occurrence of the disease and the shortness of time that has elapsed since the vaccines have been fed. In most of the studies, therefore, there have been no attempts to assess effectiveness other than by increase in antibody. In a few instances, however, it has been claimed that use of the vaccine has been followed by low rates, either in those vaccinated or in the community, which are consistent with those that might be expected as a sequel to use of an effective vaccine. Conversely, no data as to increase or continued high incidence have been reported which would indicate lack of efficacy. On the basis of our present knowledge of the immunology and pathogenesis of poliomyelitis, it is generally agreed that assumption of effectiveness is reasonable, provided virus excretion and antibody response have occurred.

Richard G. Skinner Jr., M.D., Chairman
Poliomyelitis Medical Advisory Committee

Dade County Community Polio Program Progress Report

The Dade County Health Department, the University of Miami School of Medicine, and the Dade County Medical Association are currently conducting a field trial with live attenuated polio virus vaccine. The objective of this project is to test the hypothesis that oral trivalent polio vaccine, when given to a high percentage of a population, will virtually eradicate poliomyelitis from a community.

A single oral 2 milliliter dose of the Lederle-Cox trivalent poliomyelitis vaccine, containing approximately 1.2 million virus particles of each of the following attenuated strains, will be given: Type 1 (SM strains), Type 2 (MEF-1 strains) and Type 3 (Fox strains).

An effort will be made to give this vaccine to all county residents less than 40 years of age, approximately 520,000 people. Preliminary data suggest that 10 per cent of the residents over 40 are being fed the vaccine, and in addition, 10 per cent of those being fed are nonresidents. The estimated total feedings will be approximately 600,000.

Approximately 8,000 people including University of Miami students were fed between February 3 and February 15, 1960. On February 16, widespread community feedings were begun, primarily in the public school system. By March 1, records of over 150,000 feedings have been received. By May 16, all feedings of oral vaccine will probably end until late fall 1960.

From January 25 through February 6, 1960, survey teams visited 1,500 randomly selected households in Dade County. They collected certain interview data concerning polio and other immunizations from 92 per cent of the selected households. An effort was made to collect blood specimens from all children less than 14 years of age and from one third of the persons 14 years and over in these households. A total of 1,300 bloods have been collected. The tabulation by age, socioeconomic groups and other items is currently being completed. From approximately May 16 to July 1, a second blood specimen will be obtained from these same persons. The paired sera will be titrated by tissue culture techniques for neutralizing antibodies against all three types of polio by the cooperating laboratories, the Florida State Board of Health Central Laboratory in Jacksonville and the Variety Children's Research Foundation Laboratory in Miami.

In order to determine the antigenic potency of the trivalent vaccine, paired sera have been or will be obtained from the following groups:

600 young adults (primarily University of Miami students) who have never received Salk immunization

200 young adults (primarily University of Miami students and Air Force personnel and dependents) who have received three or more Salk injections

200 infants and preschool children (primarily from Health Department Clinics) who have received no Salk injections

2,500 elementary school students (representing 60 to 70 per cent of six representative elementary schools in the county)

The paired sera will be titrated by tissue culture techniques for neutralizing antibodies. Several hundred specimens will be determined both three and five weeks after feeding and a similar number by both the metabolic inhibition and the cytopathogenic technique.

The mass immunization program, which is voluntary and free, utilizes private physicians' offices, schools, regular Health Department clinics, special community clinics, industrial clinics, mobile units, fairs, and all gatherings where eligible residents congregate. The data included on the simple information form and request for vaccination are being placed on IBM cards, alphabetized, and filed.

Careful surveillance for polio and polio-like diseases and complete investigation of alleged reaction to the vaccine are being carried out by the epidemiologist at the Dade County Health Department, supported by the routine and reference laboratory facilities of the State Board of Health, the Variety Children's Research Foundation Laboratory, and the Jackson Memorial Hospital, as well as reference services in other laboratories.

In addition to an independent study being conducted by Dr. Henry Gelfand of the United States Public Health Service and by Dr. Murray and associates of the United States Bureau of Standards, there is underway weekly sampling of the sewage system of Dade County from 14 separate points for the isolation and identification of enteroviruses.

M. EUGENE FLIPSE, M.D.

Eighty-Seventh Annual Meeting
Florida Medical Association
May 26-29, 1961
Miami Beach

American Medical Association 109th Annual Meeting Miami Beach, June 13-17, 1960

The 109th Annual Meeting of the American Medical Association will be a forum presented by some of the nation's top scientific brains. Approximately 2,000 physicians, all outstanding in their field, will participate in presenting the scientific program of the meeting to be held in Miami Beach, June 13-17. It will be the first meeting in Miami Beach, and the first annual meeting in the South since 1932. The 1954 Clinical Meeting was held in Miami.

At this meeting in this famous resort city of his home state, Dr. Louis M. Orr of Orlando, President of the American Medical Association, will relinquish the association's highest office to Dr. E. Vincent Askey of Los Angeles. Dr. Orr, the first Florida physician to hold this important post, has filled it with great distinction and is now rounding out a most successful year.

On the program are two general scientific meetings in the Grand Ballroom of the Fontainebleau Hotel, and other lectures, symposiums, and panel discussions in the Fontainebleau, in the Eden Roc Hotel, and in the new, air-conditioned Miami Beach Exhibition Hall. Sessions on dermatology, being held jointly with the Society for Investigative Dermatology, will be in the di Lido Hotel.

The opening general scientific meeting, Monday afternoon, June 13, will begin with the Joseph Goldberger Lecture on Clinical Nutrition. Dr. Carl A. Lincke, chairman of the American Medical Association's Council on Scientific Assembly, will preside at this meeting.

The lecture will be followed by a symposium on nutrition, including an address by Dr. Grace A. Goldsmith, Professor of Medicine, Tulane University School of Medicine, New Orleans, on "Highlights on the Cholesterol—Fats, Diets and the Atherosclerosis Problem."

The second general meeting will be a symposium on "Evaluation and Preparation of Patients for Anesthesia and Surgery," Tuesday morning, June 14, to which the sections on Anesthesiology, Diseases of the Chest, General Practice, Internal Medicine, Pediatrics, Pathology and Physiology, and Surgery have contributed. Participating will be Drs. Meyer Saklad, Providence, R. I.; Thomas Rardin, Columbus, Ohio; Eugene Turrell, Milwaukee, Wis.; John S. LaDue, New York City; Arlie R. Mansberger Jr., Balti-

Beaches in the Miami area.

more; George Meneely, Nashville, Tenn.; Robert M. Smith, Boston, and C. Rollins Hanlon, St. Louis.

Section Programs.—What is new in surgery will be explored during a symposium and panel discussion on Wednesday morning. The program was developed from suggestions obtained from a survey of the heads of departments of surgery in the nation's medical schools.

The symposium will be on "Recent Advances in Treatment of the Cancer Patient," with an introduction to the problem, including methods of decreasing spread of cancer cells during operations, being presented by Dr. Warren H. Cole, Chicago. Dr. Cole also will serve as moderator of the panel on "Current Status of the Treatment of Advanced Cancer of the Thyroid and Breast."

Dr. Arthur M. Master, New York City, will speak on "Effort, Occupation (including physicians) in Coronary Occlusion" during a symposium on Medical Chest Emergencies, and Dr. John F. Briggs, St. Paul, Minn., will discuss "Pulmonary Embolism."

Dr. John H. Moyer, Philadelphia, will moderate a symposium on "Edema—Its Physiology and Use of Newer Diuretics in Its Treatment." Dr. Irving S. Wright, New York, will moderate a symposium on "Pathogenesis and Treatment of Thromboembolic Phenomena." Dr. Daniel C. Moore, Seattle, Wash., will take part in a session on "Newer Trends in Diagnosis and Treatment," discussing "Oxygen—The Rational Therapy for Systemic Toxic Reactions from Local Anesthetic Drugs."

There will be panel discussions on "Tumors of the Trachea and Bronchial Tree," with Dr. Paul H. Holinger, Chicago, moderator, and one on "Disseminated Diseases of the Chest," with Dr. Harold O. Peterson, Minneapolis, moderator.

Highlights of other section meetings include:

Nervous and Mental Diseases.—Dr. E. S. Gurdjian, Detroit, "Critique of Occlusive Disease of the Carotid Artery and the Stroke Syndrome." Dr. Leo H. Bartemeier, Baltimore, "Comments on the Relations Between Psychiatrists and Other Physicians."

Obstetrics and Gynecology.—Dr. Stirling G. Pillsbury, Long Beach, Calif., "31,595 Deliveries with One Maternal Death." Jerome M. Kummer, Santa Monica, Calif., "An Answer for Criminal Abortion."

Internal Medicine.—"Symposium on Hypocholesteremic Drugs." Dr. Walter L. Palmer,

Chicago, "The Billings Lecture: Causality in Peptic Ulcer." Dr. Rudolph H. Kampmeier, Nashville, Tenn., "Collagen Diseases—Some Unanswered Questions."

Laryngology, Otology, and Rhinology.—Dr. George A. Sisson, Syracuse, N. Y., "Problems and Complications in Head and Neck Surgery." Dr. C. M. Kos, Iowa City, Iowa, "Five Year Results of Stapes Mobilization and Current Results with Vein Plug Stapedeoplasty."

Preventive Medicine.—Dr. Jan H. Tillisch, Rochester, Minn., "Medical Aspects of Safety in the Air." Dr. Robert B. Stonehill, San Antonio, Texas, "Air Travel and the Cardiopulmonary Patient," a film presentation.

Orthopedic Surgery.—Dr. Sidney Keats, Newark, N. J., "Surgery of the Extremities in the Treatment of Cerebral Palsy." Dr. H. R. McCarroll, St. Louis, Mo., "The Management of Complicated Ununited Fractures of the Tibia and Fibula."

Pediatrics.—Dr. Leonard S. Sommer, Miami, moderator, "Symposium on Congenital Heart Disease—Present-day Status from Viewpoint of Practitioner of Medicine."

Miscellaneous Topics.—A half-day session on the "Management of the Older Patient." Participants include Dr. Philip Thorek, Chicago.

Exhibits.—About 290 exhibits will be on display in the Miami Beach Exhibition Hall, representing the most outstanding exhibits selected from 540 applications.

A new special exhibit on Body Fluid Disturbances, offering a complete course in body fluids, will be presented in its entirety on two days. Different aspects will begin at specific times to permit physicians to attend only those parts in which they are particularly interested.

A special exhibit on fractures will include booths on fractures of the ankle, hip, wrist, tibia and fibula, children's fractures, and fractures resulting from falls on the outstretched hand. About 50 prominent orthopedic surgeons will take part in the demonstrations at this exhibit.

Specials on Pulmonary Function and Fresh Tissue Pathology also will be highlighted in the Scientific Exhibition area.

An outstanding program of motion pictures and television, which will be coordinated with the rest of the scientific program, will be presented also in the Miami Beach Exhibition Hall.

Health Fair Attracts Large Crowds at Sarasota

The Sarasota Health Fair, held in the Municipal Auditorium at Sarasota on February 15 to 18, 1960, was the first venture of its type to be staged on the West Coast of Florida. The Sarasota County Medical Society, with less than 100 members, in cooperation with the Sarasota Herald-Tribune was sponsor. Two health fairs previously had been held on the East Coast—one in West Palm Beach in connection with the Palm Beach County Fair and the other in Miami during a meeting of the American Medical Association.

Dr. James E. Kicklighter, President of the Society, served as chairman of the Committee on Arrangements. A group of 30 physicians donated a portion of their time to be in attendance at the event, answering questions on all medical problems no matter how small. Working in shifts, the physicians were on duty at the Fair throughout the day and in the evening.

Law enforcement agencies in Sarasota County, including the Sheriff's Department and the Police Department, cooperated in the Fair, and uniformed officers were on duty throughout the three day event.

A portion of the crowd visiting exhibits and obtaining data on blood tests.

Dr. Ralph W. Jack of Miami, President of the Florida Medical Association, cuts the ribbon signifying official opening of the Sarasota Health Fair. Others (from left) are Don Laurent, Administrator of Sarasota Memorial Hospital; Frank L. Hoersting, Mayor of Sarasota; Dr. James E. Kicklighter, President of the Sarasota County Medical Society, State Trooper John Campbell, Sheriff Ross Boyer, William Klaus, and James Spanos, Chairman of the County Commission.

Some 50 exhibits were set up in the auditorium. They were supplied by various national, state and local health groups, such as the Oak Ridge Institute for Nuclear Studies, American Pharmaceutical Association, United States Navy, American Dental Association, Sloan-Kettering Research Institute, American Medical Association, Blue Cross–Blue Shield, Florida State Board of Health, Alcoholic Rehabilitation Program and the College of Medicine of the University of Florida.

Dr. Ralph W. Jack of Miami, President of the Florida Medical Association, cut the ribbon signifying official opening of the Fair at six o'clock Monday evening, February 15. At that time he stated: "The Sarasota Health Fair is of particular significance to us in Florida Medicine because it marks the first time anywhere in the country, to our knowledge, that a medical society the size of the local group of doctors has undertaken so ambitious a project for the public."

Visitors coming through the front door of the auditorium were ushered to the right for viewing the hospital corridor, exhibited by Sarasota Memorial Hospital, which included laboratories, blood bank, operating room, iron lung, nursery and all the other services of a modern hospital. After this exhibit, the visitor passed among decorated booths explaining health centers, hospitalization plans, dietetics, atomic energy, blood pressure determinations, careers in medicine, space medicine, dental displays, immunization, highway safety, and artificial respiration.

The Sarasota County Health Department set up a blood testing center in an open tent near the auditorium. Volunteer nurses and other personnel tested the blood of visitors for sugar, low hemoglobin and other defects.

During the initial hour of the Fair, 358 persons passed into the auditorium. At the close, 22,000 had visited the exhibition; of this number, 6,000 were high school students.

Dr. Kicklighter stated that the Society began planning the Fair in April 1959 and that it looked at times as if the project would have to be abandoned because of the many details involved in such an undertaking. The Committee on Arrangements, however, refused to admit defeat and went on with plans. He commented that since at the outset the Society had its doubts the Fair would attract 10,000 persons, all the members were highly pleased at the reception given it by more than twice this number.

Twenty-Sixth Annual Meeting American College of Chest Physicians Miami Beach, June 8-12, 1960

The American College of Chest Physicians will hold its five day annual meeting in Miami Beach next month. The dates of this twenty-sixth annual meeting, which will have its headquarters at the Saxony Hotel, are June 8-12, 1960. Dr. Seymour M. Farber, San Francisco, President of the College, will preside at the meeting. Dr. M. Jay Flipse, Miami, President-Elect, will take office as President following the President's Banquet on Saturday evening, June 11. Dr. Alexander Libow, Miami Beach, is serving as Chairman of the Committee on General Arrangements for the meeting. Serving as Regent of the College for the State of Florida is Dr. Arnold S. Anderson, St. Petersburg.

Dr. Thomas Mattingly, Washington, D. C., Chairman of the Cardiovascular Section, Committee on Scientific Program, and Dr. R. Drew Miller, Rochester, Minn., Chairman of the Pulmonary Section, have arranged an exceptional scientific program which will include papers by: Drs. Philip Samet, Eugene M. Fierer and William H. Bernstein, Miami Beach; Drs. E. Charlton Prather, James O. Bond, Eldert C. Hartwig, and F. P. Dunbar, Jacksonville; Drs. Mark W. Wolcott, Thomas J. Kiernan and George L. Baum, Coral Gables; and Dr. E. Sterling Nichol, Miami. Among important topics to be discussed are: "Newer Diagnostic Aids in Cardiology," "Cardiac Resuscitation," "Pulmonary Function in Cardiac Disease," "Carcinoma of the Lung: A Study of Five-Year Survivals Following Surgery," and "Effect of Cardiac Arrhythmias on the Circulation of the Vital Organs."

A program of scientific motion pictures to be presented on Friday, Saturday and Sunday, June 10, 11 and 12, has been arranged by Dr. Paul H. Holinger of Chicago.

Other highlights of the meeting will include the presentation of the College Medal at the President's Banquet on June 11 and the Convocation at which 100 physicians will be awarded their certificates of Fellowship in the College.

Additional aspects of the scientific program will be the Postgraduate Seminars on Wednesday, June 8. There will be two morning and two afternoon sessions devoted to cardiovascular and pulmonary discussions. The tuition fee of $7.50 for each postgraduate seminar will be included in the registration fee of $25 for nonmembers. Physicians from Florida lecturing at these sessions are: Drs. Jack Reiss, Mark W. Wolcott and Jim S. Jewett, Coral Gables; Ralph Jones Jr., Charles F. Tate Jr., DeWitt C. Daughtry, Francisco A. Hernandez, Robert S. Litwak, Francis N. Cooke, Marvin S. Meitus and Fred Wasserman, Miami; Richard G. Connar, and Hawley H. Seiler, Tampa; Ivan C. Schmidt, West Palm Beach; Paul N. Unger, Philip Samet and David A. Nathan, Miami Beach; and Robert J. Boucek, North Miami Beach.

The Fireside Conferences will be held on Friday evening, June 10, and will include such subjects as: "Biopsy and Cytology in Diagnosis of Pulmonary Diseases," "Mechanical Assists to the Circulation in Heart Failure," "Surgery of Lung Tumors," "Allergy in Pulmonary Disease," and "Aerosol Therapy." Some of the discussion leaders will be: Drs. N. Joel Ehrenkranz, Paul W. Boyles and E. Sterling Nichol, Miami; Ballard F. Smith, Fort Lauderdale; Fred Wasserman and Mark W. Wolcott, Coral Gables; and James O. Bond and E. Charlton Prather, Jacksonville.

Also of interest will be a film presentation of a television broadcast on the subject "Report to the People on Lung Cancer." Among the participants will be Dr. M. Jay Flipse of Miami.

There will also be six round table luncheons daily on Friday, Saturday and Sunday, June 10, 11 and 12, at which the following physicians from Florida will participate: Drs. Robert S. Litwak and N. Joel Ehrenkranz, Miami.

This will be the first time the American College of Chest Physicians has held an annual meeting in Miami Beach. The meeting will be directly in advance of the American Medical Association meeting.

Florida Medical Association Officers Attend Congressional Dinner

Officers of the Florida Medical Association, the Florida Congressional Delegation, and other key physicians who attended the annual Florida Medical Association Congressional Dinner held March 9, 1960 in Washington included (front from left) Dr. Ralph W. Jack, President; Congressmen Paul Rogers, William Cramer, James Haley, A. S. Herlong and D. R. Matthews; and Dr. Walter J. Glenn; (back from left) Drs. H. Phillip Hampton, Leo M. Wachtel, President-Elect, Samuel M. Day, Secretary-Treasurer, Eugene G. Peek Jr., Edwin H. Andrews, Francis T. Holland and Edward R. Annis.

Due to a heavy snowstorm, Senators Spessard Holland and George Smathers and Representatives Charles Bennett, Robert Sikes and Dante Fascell were unable to be present for the dinner meeting.

Postgraduate Seminar In Arthritis and Related Diseases Hollywood, June 11-12, 1960

Immediately following the Annual Meeting of the American Rheumatism Association and immediately preceding the Annual Meeting of the American Medical Association, a Postgraduate Seminar in Arthritis and Related Diseases will be held at the Diplomat Hotel in Hollywood-by-the-Sea. The dates for this meeting are June 11 and 12, and the convenient location is adjacent to Miami Beach. The sponsors of the Seminar are the Florida Chapter of the Arthritis and Rheumatism Foundation, the University of Miami School of Medicine, the College of Medicine of the University of Florida, and the South Florida Rheumatism Society, which is affiliated with the American Rheumatism Association. The course is acceptable for eight hours of Category I credit by the American Academy of General Practice, and the tuition is $15.

In announcing the meeting, Dr. Woods A. Howard, of Lakeland, Chairman of the Medical and Scientific Committee of the Florida Chapter of the Arthritis and Rheumatism Foundation, stated that emphasis will be placed on the diagnosis and management of the more common rheumatic disorders. The faculty includes Drs. Leon Sokoloff, Gene H. Stollerman, Alexander B.

Gutman, Edward F. Rosenberg, Charles Ragan, Joseph Lee Hollander, Philip S. Hench, Lawrence E. Shulman, Marian W. Ropes, Ephraim P. Engleman, David S. Howell, Theodore A. Potter, Morris Ziff, Theodore B. Bayles and Edward W. Lowman.

Further information may be obtained from the Seminar Committee, Florida Chapter, Arthritis and Rheumatism Foundation, 1206 Huntington Medical Building, Miami 32.

What Is the Florida Medical Assistants' Association?

Doctors, are you satisfied with your office medical assistant?

Is she taking advantage of all opportunities to improve her knowledge and education, the better to serve the medical profession and the public?

Is she a good public relations representative for the medical profession?

Does she belong to a medical assistants' organization?

Are you aware that such an organization exists?

There is such an organization here in Florida. Its name is the Florida Medical Assistants' Association. It was formed in 1954 through the united efforts of groups in Duval and Hillsborough counties. It now has chapters in Duval, Hillsborough, Pinellas, Palm Beach, Polk and Orange counties with approximately 200 members.

The organization has the full support of the Florida Medical Association and the American Medical Association. Patterned after medical societies, it is composed of county chapters which comprise the state organizations, which in turn is a component of a national association. The American Association of Medical Assistants was endorsed by the American Medical Association at its 1956 meeting in Seattle. At present there are 25 affiliated state units and over 8,000 members. There are 10 physician advisors, one appointed by the American Medical Association from its Board of Trustees.

The first annual convention was held in San Francisco in October 1957; others followed in Chicago in October 1958 and in Philadelphia in October 1959. The 1960 convention will be in Dallas in October. The Association now has an office at 510 Dearborn Street in Chicago just across the street from headquarters of the American Medical Association. An executive secretary was employed in 1959.

To acquaint you further with the Who, What, When, Where and Why of the Florida Medical Assistants' Association:

Who. . .

We who comprise the membership are the women who assist the doctors of Florida. We are the nurses, receptionists, secretaries, bookkeepers and technicians. We handle the business and technical details of the doctors' offices, thereby conserving the physician's time. Our respect for the medical profession makes us strive for better public relations; we endeavor to be ethical in all dealings with patients and in our participation in the civic affairs of the community.

What . . .

In their efforts to elevate the standards or procedure in doctors' offices and clinics individual county societies have joined forces with other county organizations to form a state association. This association is not, and shall never become, a trade union or collective bargaining agency. Its purpose is a sincere and cooperative interchange of knowledge and ideas on how to improve public relations in medical endeavors.

When . . .

The Florida Medical Assistants' Association was organized in 1954 and has continued to grow steadily in members and enthusiasm. It is endorsed by the Florida Medical Association with the following advisors: Drs. Edward Annis, Robert F. Dickey, and W. Tracy Haverfield, of Miami, and Francis T. Holland, of Tallahassee.

Where . . .

Each member is a member of her local county organization, which is endorsed by its county medical society, and is also a member of the state and national organization.

Why . . .

The purposes of this Association are: To bring members into a closer relationship, thereby promoting mutual understanding and a spirit of cooperation between the members; to promote the interest of the members and to secure better public relations; to provide a means whereby

all medical secretaries and assistants may become associated and work together toward the common good of the medical profession; to enlarge the opportunities of the members through education, scientific and business training, and the participation in vocational activities; and in general, to promote the highest standards of endeavor among medical assistants.

In Duval County, the members of the local chapter have completed two study courses at Jacksonville University, "Anatomy and Physiology" and "Medical Terminology," taught by professors of the University. Dr. Leila Wells gave four hours of instruction on laboratory procedure in June 1959. There was a symposium on Dec. 12, 1959, at Sellers Auditorium, which was well attended and in which several local doctors participated, giving unselfishly of their time. A statewide educational program is now being set up through the University of Florida, which will be adaptable to all chapters in Florida. All chapters in the state have similar educational programs through the Universities, and at the monthly meetings physician speakers are most popular; medical films are shown, and office procedures are explained.

Each chapter has its philanthropic projects. Methods of fund raising vary from rummage sales to fashion shows and dinners.

On several political issues of mutual interest, the Assistants' Association has recorded its support or its opposition along with that of organized medicine.

The 1959-1960 officers are: President, Mrs. Muriel Martin, St. Petersburg; Vice President, Mrs. Edith Jones, Jacksonville Beach; President-Elect, Mrs. Iris Longworth, Tampa; Recording Secretary, Mrs. Jessie Knott, Orlando; Corresponding Secretary, Miss Mary L. Merrell, St. Petersburg; Treasurer, Miss Carmeline Cannella, Tampa; Parliamentarian, Miss Pearl Laffitte, Jacksonville; and Historian, Mrs. Florence Van Caeyzelle, Jacksonville.

The annual state meeting will be held on June 3, 4 and 5, 1960 in Jacksonville at the Hotel Robert Meyer. Doctors are invited to attend local and state meetings to learn more about the organization and, above all, are urged to send their medical assistants to learn what the Florida Medical Assistants' Association has to offer its members.

Elizabeth Critchfield, Chairman
Public Relations Committee
Florida Medical Assistants' Association

OTHERS ARE SAYING

Economics of Medicine

Many years ago, in the horse and buggy days when a doctor's transportation expenses amounted to a twenty-five dollar horse, a hundred dollar buggy, plus the cost of oats, and you were able to obtain a free lunch with a nickel glass of beer, doctor's fees were settled for a chicken or a dozen eggs. Public reaction was the only criterion in limiting the physicians' fees. There was no active influencing attempt to fix fees by medical care plans such as Medicare, insurance companies, politicians, California fee schedule, or the like. Physicians commanded respect and were able to provide for their families in a manner equal to that of the man in the upper ten per cent bracket in any community.

Today our Washington committees, in addition to shelving self-employed pension plans, limiting entertainment expenses for physicians, and many other hidden ruses, as contrasted to the relief extended to corporate business executives, have definitely made it more attractive to the young man to embark on a business career. True enough one must be dedicated to medicine to sacrifice the time and effort required in training, to sacrifice the time spent away from one's family and the hours required to practice good medicine; to sacrifice at times one's own health considerations for those of our patients. But even though we are dedicated, we need not be squeamish about insisting upon receiving adequate compensation for our time and services. In this day and age when one's automobile expenses alone run close to several thousand yearly, we should get more than the chicken, or the eggs that it produces.

Don't let preconceived plans or fee schedules or politicians dictate to you—if you do, socialized medicine will descend upon us—sooner than you think. We are asked by the AMA to adjust our fees for the aged. I say yes, by all means let's—for those who cannot afford our regular fees —provided that all other businesses such as the taxi cab, newspaper publisher, restaurants, food stores, clothiers, builders, landlords, drug stores, hospitals and insurance companies do likewise. This would indeed be noble of all of the above mentioned, including ourselves, but should we be penalized financially for extending life and the comfort of living?

We do not have to agree to follow "this plan" or that "fee schedule" or anything else that further curtails our economic growth from keeping pace with our present inflation. It is time for us to say NO to many of these discriminatory limitations. Why not tax corporate big business and insurance companies to support such plans and then we will do our share also. Therefore, continue to charge what you feel is just—ignore limiting fee schedules but do conform to your colleagues' and the local fees. Let us say again NO to some of these fee-curtailing plans instead of accepting them as noble ideas. Give the patient who is pressed financially a "break" as has always been the tradition of medicine and let us practice economically unhindered.

Our medical association, of course, does not condone excessive charges. There are a few individuals who tend to "soak" frequently. Our Grievance Committee will justly correct such practices. You should advise patients who complain to you regarding others to put their complaints in writing to the Grievance Committee. This is the only way you can control the criticism of our economy and thereby preserve the right to practice medicine subject only to the limits imposed upon you by the ethics of your fellow man and by the opinion of the patients in your community.

Miles J. Bielek, M.D., President
Broward County Medical Association
The Record
September 1959

BLUE SHIELD

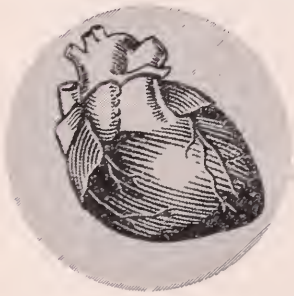
Which Path to Medical Security?

It is now 20 years since the medical profession gave birth to prepaid medical care, but its ultimate patterns of operation and control are yet to be determined.

While most of us recognize that the public will make the eventual decision, nevertheless doctors have it within their power to influence that decision. For the simple fact is that, in the long run, the people will support that system of medical care prepayment which offers them the best assurance of satisfactory professional service through physicians and institutions of their own choosing. *(Continued on page 1404)*

Congenital Heart Disease Symposium

program for **MIAMI BEACH***



AMA Section on Pediatrics

offers an outstanding panel, one of more than 300 scientific presentations scheduled for the

109th ANNUAL MEETING
June 13—17

Moderator.....**Leonard S. Sommer,** Miami, Florida
Pediatric Cardiologist..**Catherine Neill,** Baltimore, Md.
Roentgenologist.....**Robert Cooley,** Galveston, Texas
Anesthesiologist..**Kenneth K. Keown,** Columbia, Mo.
Surgeon.....**John K. Derrick,** Galveston, Texas

*This symposium will be held Wednesday, June 15, at 10:30 A.M. in the Fontainebleau Hotel.

Advance hotel and meeting registration forms appear in the first issue of JAMA each month.

The first specific aldosterone-blocking agent...

ALDACTONE™

effectively extends the medical control of edema or ascites.
It introduces a new therapeutic principle in the treatment of...

CONGESTIVE HEART FAILURE • HEPATIC CIRRHOSIS
THE NEPHROTIC SYNDROME • IDIOPATHIC EDEMA

ALDACTONE introduces a new class of therapeutic agent, the aldosterone-blocking agent providing:

satisfactory relief of resistant or advanced edema even when all other agents, alone or in combination, are ineffective or are only partially effective.

A New Order of Therapeutic Activity

ALDACTONE acts by blocking the effect of aldosterone, the principal mineralocorticoid governing the reabsorption of sodium and water in the distal segment of the renal tubules.

By so doing Aldactone establishes a fundamentally new and effective approach to the control of edema or ascites, including edema resistant or unresponsive to conventional diuretic agents.

Further, because of its different site and mode of action in the renal tubules, Aldactone has a true, highly valuable synergistic activity when used with a mercurial or thiazide diuretic.

What Physicians May Expect of Aldactone

It is fully expected that Aldactone will change present medical concepts of the therapeutic limitations of managing edema. Many patients living in a greater or lesser state of edematous invalidism can now be edema-free. To others, gravely ill, Aldactone will be life-saving.

When used alone, Aldactone will produce a satisfactory diuresis in about half of those patients whose edema is resistant to conventional diuretic agents.

When Aldactone is used in a comprehensive therapeutic regimen, which includes a mercurial or a thiazide diuretic, a satisfactory diuresis and relief of edema may be expected in approximately 85 per cent of edematous patients *who would not otherwise respond.*

DOSAGE: For most adult patients the optimal dosage of Aldactone, brand of spironolactone, is 100 mg. four times daily. Aldactone should be administered for at least four or five days before appraising the initial response, since the onset of therapeutic effect is gradual when it is used alone. Aldactone manifests accelerated activity with greater response as early as the first and second days when used in combination with a mercurial or thiazide diuretic.

SUPPLIED: Aldactone is supplied as compression-coated yellow tablets of 100 mg.

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Streptokinase-Streptodornase Lederle

BUCCAL Tablets

conditions for a fast & comfortable comeback

Host reaction to injury or local infection has a catabolic and an anabolic phase. The body responds with inflammation, swelling and pain. In time, the process is reversed. VARIDASE speeds up this normal process of recovery.

By activating fibrinolytic factors VARIDASE shortens the *undesirable phase,* limits necrotic changes due to inflammatory infiltration, and initiates the constructive phase to speed total remission. Medication and body defenses can readily penetrate to the affected site; local tissue is prepared for faster regrowth of cells.

In infection, the fibrin wall is breached while the infection-limiting effect is retained. In acute cases, response is often dramatic. In chronic cases, VARIDASE Buccal Tablets can stimulate a successful response to primary therapy previously considered inadequate or failing.

for routine use in injury and infection
...new simple buccal route

VARIDASE Buccal Tablets should be retained in the buccal pouch until dissolved. For maximum absorption, patient should delay swallowing saliva.

Dosage: One tablet four times daily usually for five days.

When infection is present, VARIDASE Buccal Tablets should be given in conjunction with ACHROMYCIN® V Tetracycline with Citric Acid.

Each VARIDASE Buccal Tablet contains: 10,000 Units Streptokinase and 2,500 Units Streptodornase.

Supplied: boxes of 24 and 100 tablets.

1. Innerfield, I.: Clinical report cited with permission
2. Clinical report cited with permission

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severe bruises . . . swelling . . . cleared by fifth day[2]

VARICOSE ULCER

15 years duration . . . resolved with VARIDASE[1]

INFLAMMATORY DERMATOSIS

rapidly spreading rhus dermatitis healed within a week[1]

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marked reversal in 3 days . . . returned to school . . . closure advanced[1]

THROMBOPHLEBITIS

back on his feet in a week after recurrent episode[1]

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normal routine resumed after 4 days of VARIDASE[1]

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...relief from pollen allergies

more complete than antihistamines alone... more thorough than nose drops or sprays

The miseries of respiratory allergy can be relieved so effectively with Triaminic.[1-5] Triaminic contains two antihistamines plus the decongestant, phenylpropanolamine, to help shrink the engorged capillaries, reduce congestion and bring relief from rhinorrhea and sinusitis.[1] Oral administration distributes medication to *all* respiratory membranes without risk of "nose drop addiction" or rebound congestion.[2,3]

Each Triaminic timed-release Tablet provides:

Phenylpropanolamine HCl	50 mg.
Pheniramine maleate	25 mg.
Pyrilamine maleate	25 mg.

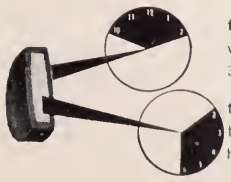
also available:

TRIAMINIC JUVELETS® ½ the formulation of the Triaminic Tablet with timed-release action.

TRIAMINIC SYRUP each teaspoonful (5 ml.) provides ¼ the formulation of the Triaminic Tablet.

References: 1. Fabricant, N. D.: E. E. N. T. Monthly **37**:460 (July) 1958. 2. Lhotka, F. M.: Illinois M. J. **112**:259 (Dec.) 1957. 3. Farmer, D. F.: Clin. Med. **5**:1183 (Sept.) 1958. 4. Fuchs, M.; Bodi, T.; Mallen, S. R.; Hernando, L., and Moyer, J. H.: Antibiotic Med. & Clin. Ther. **7**:37 (Jan.) 1960. 5. Halpern, S. R., and Rabinowitz, H.: Ann. Allergy **18**:36 (Jan.) 1960.

Relief is prompt and prolonged because of this special timed-release action



first—the outer layer dissolves within minutes to produce 3 to 4 hours of relief

then—the core disintegrates to give 3 to 4 **more** hours of relief

SMITH-DORSEY • A DIVISION OF THE WANDER COMPANY • LINCOLN, NEBRASKA

(Continued from page 1398)

Today, several contrasting programs of medical prepayment are competing for popular and professional favor—each embodying a distinct concept of the relationship between patient and doctor.

One such program is the limited cash reimbursement program of the insurance industry, which offers the insured certain dollar indemnities against certain medical contingencies, irrespective of the physician's charges for the service required.

Another major program is medicine's Blue Shield Plan, which seeks—through professionally negotiated schedules of payment and, in Florida, through the agreement of participating physicians—to assure service benefits patients of fully paid professional services.

A third program is the "closed panel" of physicians. Operating frequently under labor or other lay auspices, this plan undertakes to provide a comprehensive service through a selected group of physicians remunerated by salary or per capita allowances, regardless of the volume of service required of them.

Which of these programs most faithfully reflects the traditional pattern of American medical practice? Which program is most clearly motivated—as medicine itself is motivated—to render service to the patient and to meet the needs of all segments of the community? Which program returns the fullest value to the patient and most fairly compensates the doctor? Which program best utilizes and protects the modes and ideals of practice that have earned American medicine the envy of other lands?

Which program will the American doctor favor—in the common interest of medicine and the people?

How well the public has been informed as to the advantages of Blue Shield, and its companion Blue Cross, will become evident in the near future when federal employees are asked to choose from among several programs and benefit patterns.

Your attention is called to the Blue Shield advertisement appearing on page 1342 of this issue of The Journal.

This is the first of a series with the overall objective of reminding and reemphasizing to the medical profession of its stake in Blue Shield.

FIVE Stores NOW, to better serve you.

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FOR ACNE

NEW pHisoAc* CREAM

Therapeutic topical application suppresses and masks lesions. Dries, peels, degerms the skin. Used with **pHisoHex**® (antiseptic detergent) washings to unplug follicles, help prevent comedones, pustules and scarring.

Teen-agers like new pHisoAc Cream. It is smooth, odorless, flesh-toned, and greaseless. It spreads and dries quickly. Ask the Winthrop representative for the special booklet, **"Teen-aged? Have acne? Feel lonely?,"** containing basic home treatment routine and psychological aid for the patient.

New pHisoAc Cream contains colloidal sulfur 6 per cent, resorcinol 1.5 per cent, hexachlorophene 0.3 per cent, orthophenylphenol 0.3 per cent, and alcohol 10 per cent (w/w). Available in 1½ oz. tubes.

*pHisoAc, trademark.

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STATE BOARD OF HEALTH

Notice to Physicians on Reporting of Polio

Accurate reporting of all suspect viral infections of the central nervous system in Florida is necessary in 1960. It is of especial importance at this time because of the Dade County field trial with live polio vaccine, the recent occurrence of an outbreak of encephalitis in Pinellas County, and the fact that the different viral agents are able to cause similar clinical syndromes.

All suspect cases of viral infections of the central nervous system should have virological laboratory examination. The specimens required are acute and convalescent clotted bloods, frozen stool, and frozen spinal fluid. Instructions for collection and shipping may be obtained from each county health department.

Cases of encephalitis, paralytic polio, or aseptic meningitis should be reported promptly to the health department on the regular card, with an additional notation regarding the number of Salk injections the patient had received. Cases formerly diagnosed clinically as nonparalytic polio should now be reported as aseptic meningitis. All clinical syndromes which suggest infection of the central nervous system with some viral agent should be reported without awaiting the results of virological laboratory tests. As the results become available, the laboratories will report the etiological agent to the Florida State Board of Health as well as to the physician.

Since it is no longer possible to make an accurate diagnosis of nonparalytic polio without laboratory examination, initial reports of this syndrome will not be included in the preliminary official Florida reports of polio for this year.

Because of limited funds, the National Foundation will not pay for hospitalization of patients with nonparalytic polio.

Your

W. B. Saunders
Representative

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We Buy, Sell and Lease
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BIRTHS AND DEATHS

Births

Dr. and Mrs. George P. Graf of Winter Haven announce the birth of a son, Gary Paul, on January 11, 1960.

Deaths—Members

Cleveland, Robert H., Jacksonville ..... December 28, 1959
Coleman, John A., Plant City ..... October 19, 1959
Morris, James A., Punta Gorda ..... October 28, 1959
Thorne, James I., Miami ..... February 24, 1960

Deaths—Other Doctors

Fein, Bernard, Newark, N. J. ..... September 11, 1959
Kelly, Virgil L., Bluefield, W. Va. ..... October 10, 1959
Nash, Wm. G., Ocala ..... November 15, 1959
Rogel, Louis Frederick, South Miami ..... February, 1960
Rush, John A. Jr., Jacksonville ..... September 19, 1959
Silsby, Harry Z., Sanford ..... December 22, 1959

CORRECTION: Dr. Theodore F. Hahn, who died Aug. 20, 1959, was incorrectly listed as an Association member in the February issue of The Journal. Dr. Hahn Sr., the father of Dr. Theodore F. Hahn Jr. of Deland, had never been a member of any medical association. He was a physician; however, he had been a minister for the past 25 years.

For topical infections, choose a 'B. W. & Co.'® 'SPORIN'...

Combines the anti-inflammatory effect of hydrocortisone with the comprehensive bactericidal action of the antibiotics.

Each gram contains:
'Aerosporin'® brand Polymyxin B Sulfate 5,000 Units
Zinc Bacitracin ..... 400 Units
Neomycin Sulfate ..... 5 mg.
Hydrocortisone ..... (1%) 10 mg.
in a special petrolatum base.

Provides comprehensive bactericidal action effective against virtually all bacteria likely to be found topically.

Each gram contains:
'Aerosporin'® brand Polymyxin B Sulfate 5,000 Units
Neomycin Sulfate ..... 5 mg.
Zinc Bacitracin ..... 400 Units
in a special petrolatum base.

Offers combined antibiotic action for treating conditions due to susceptible organisms amenable to local medication.

Each gram contains:
'Aerosporin'® brand
Polymyxin B Sulfate ..... 10,000 Units
Zinc Bacitracin ..... 500 Units
in a special petrolatum base.

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STATE NEWS ITEMS

Dr. Sanford Cobb of Miami delivered the "Charge to the New Members" at the recent annual initiation banquet of the Alpha Chapter of Florida, Alpha Omega Alpha Honor Medical Society, University of Miami School of Medicine. Dr. Cobb was a faculty member of the Seminar in Anesthesiology, the first of its kind in Florida, held at the College of Medicine, University of Florida, and co-sponsored by the Department of Anesthesiology, University of Miami School of Medicine and the Division of Anesthesia, of the Department of Surgery, College of Medicine, University of Florida. Dr. Cobb's lectures were entitled "Muscle Relaxants and Consciousness" and "Certain Aspects of Hypothermia for Cardiac Surgery."

Dr. J. Basil Hall of Tavares has been made an honorary member of the Lake County Dental Society for unstintingly giving his time, talents and energies to the Society. The formal resolution adopted by the Society states that Dr. Hall "performed a major service to the Society for the institution of the preceptorship program . . . arranged for and obtained dental service and information for indigent persons in Lake County, solely through his own efforts . . . has been of great service and aid in the formation and operation of the uses and purposes of the Lake County Dental Society." Attesting Dr. Hall's membership, a scroll was presented to him at the regular meeting of the Society in Mount Dora on January 27.

The Section of Ophthalmology and Otolaryngology of the Southern Medical Association has announced that papers by physicians of either specialty in the area of the Association are being accepted for consideration for presentation at the next annual meeting in St. Louis, Mo., October 31-November 3. The paper or an abstract may be sent to the Secretary of the Section, Dr. Albert C. Esposito, Suite 1212, First Huntington National Bank Bldg., Huntington, W. Va.

Dr. Jacob A. Glassman of Miami, Assistant Clinical Professor of Surgery at the University of Miami School of Medicine, was one of the principal speakers at the Eighth Annual Interim

(Continued on page 1420)

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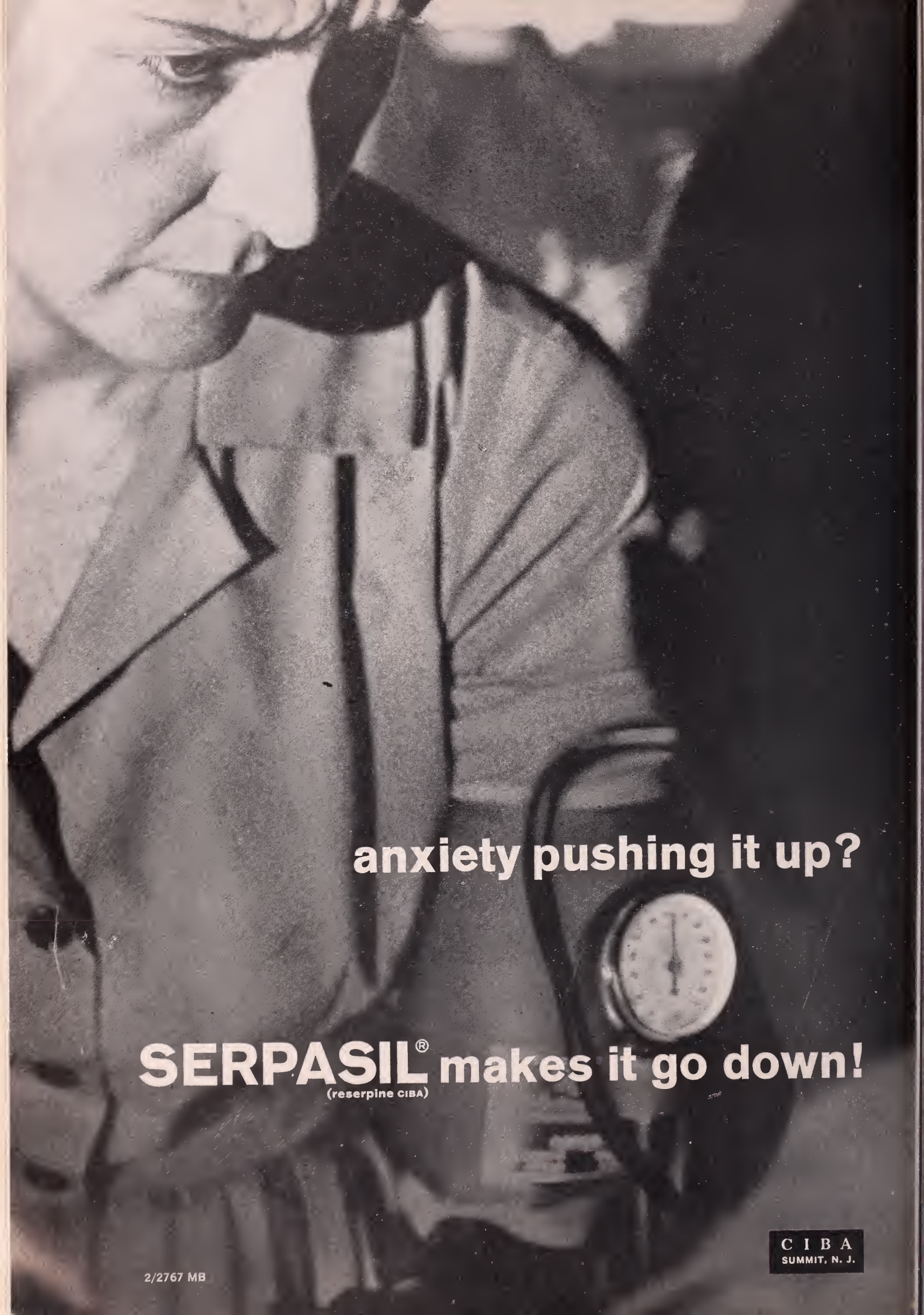
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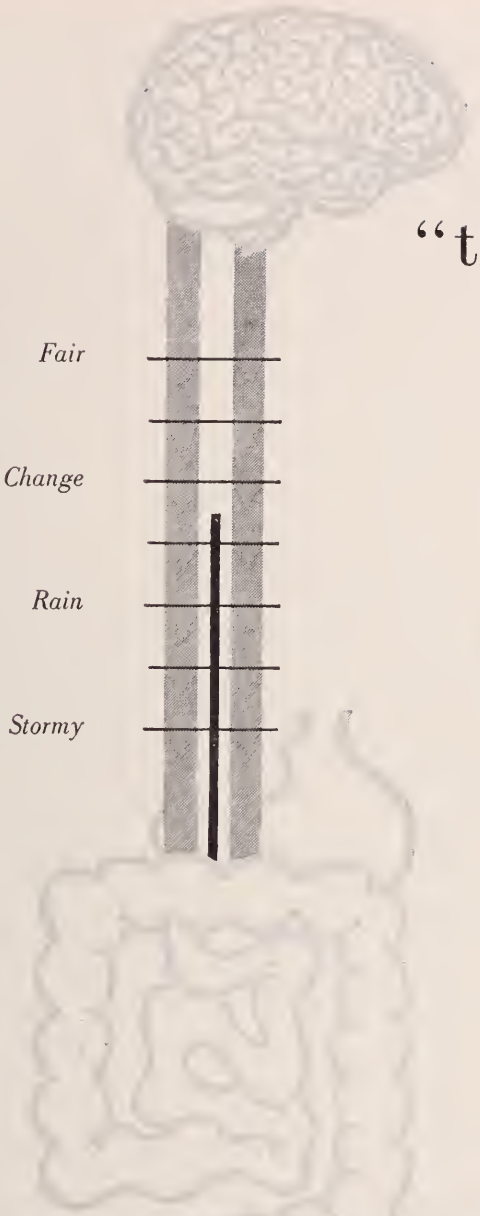

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References: 1. Ayd, F. J., Jr.: Bull. School Med., Univ. Maryland *44*:29, 1959. 2. Azima, H., and Vispo, R. H.: A.M.A. Arch. Neurol. & Psychiat. *81*:658, 1959. 3. Lehmann, H. E.; Cahn, C. H., and de Verteuil, R. L.: Canad. Psychiat. A. J. *3*:155, 1958. 4. Mann, A. M. and MacPherson, A. S.: Canad. Psychiat. A. J. *4*:38, 1959. 5. Sloane, R. B.; Habib, A., and Batt, U. E.: Canad. M.A.J. *80*:540, 1959. 6. Straker, M.: Canad. M.A.J. *80*:546, 1959. 7. Strauss, H.: New York J. Med. *59*:2906, 1959.

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Ref: Plotz, M.: Modern Management of Obesity, J.A.M.A. 170: 1513-1515 (July 25) 1959.

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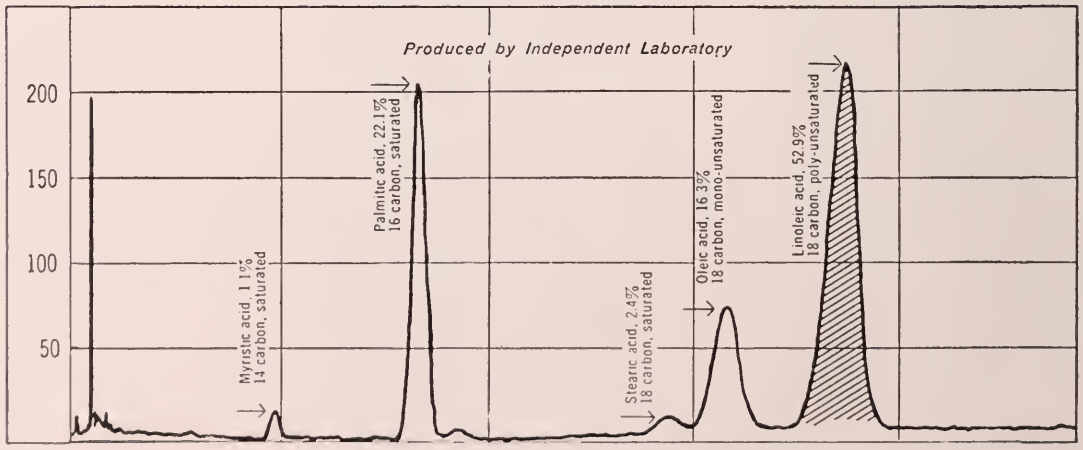

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(Continued from page 1408)

Scientific Meeting of Phi Lambda Kappa held at the Deauville Hotel, Miami Beach, March 23. Dr. Glassman's subject was "A Critique on Aspiration Biopsy for Suspect Carcinoma of the Breast."

Dr. Herbert W. Virgin Jr. of Miami is chairman of arrangements for the annual luncheon of alumni of Northwestern University Medical School being held June 14 in the Roney-Plaza Hotel, Miami Beach, during the time of the meeting of the American Medical Association. Dean Richard H. Young will be the speaker.

The 6th International Congress of Internal Medicine will be held in Basle, Switzerland, August 24-27. English is one of the official languages for the Congress in which 70 leading internists from all over the world will participate in the principal scientific program.

Dr. Nathan S. Rubin of Pensacola participated in the program of the Gulf Coast Sight Conservation Seminar held in Pensacola March 10. Dr. Rubin presented an illustrated lecture on "The Doctor Views Eye Injuries."

Drs. Edward A. Talmage and J. Gerard Converse of Miami have received a Certificate of Appreciation from the New York State Society of Anesthesiologists for their presentation of the scientific exhibition "Myocardial Insufficiency During Anesthesia and Surgery" at the 13th Post-Graduate Assembly of the Society in New York City representing the University of Miami School of Medicine.

The Yale University School of Medicine will celebrate a century and a half of existence on October 28-29. The occasion will be marked by meetings, exhibitions and addresses. Among the notable group of guest speakers will be Sir Howard Florey of Oxford, England. In October, 1810, the Connecticut General Assembly granted a charter to Yale College for the establishment of the Medical Institution of Yale College, and the fifth medical school in the United States came into being.

The University of Illinois College of Medicine, Department of Otolaryngology, will offer an intensive postgraduate basic and clinical program for practicing otolaryngologists, September

24-30. It is designed to bring to specialists a wide variety of current advances in management, therapy and philosophies. Information may be obtained from the Department of Otolaryngology, University of Illinois College of Medicine, 1853 West Polk Street, Chicago 12.

Dr. Norris M. Beasley of Fort Lauderdale was one of the featured speakers at the 21st Annual Allergy Forum held April 2-5 at Oklahoma City, Okla.

Drs. Walter W. Sackett Jr. and Harvey Blank of Miami and Dr. Irwin Perlmutter of Coral Gables participated in the scientific program of the 12th Annual Scientific Assembly of the American Academy of General Practice held March 21-24 in Philadelphia. Each of the physicians had an exhibit in the Scientific Exhibit Section. The title of Dr. Sackett's portrayal was "Baby Feeding: Prolonged Intervals, Early Use of Solids;" Dr. Blank's "Systemic Treatment of Dermatomycoses with Griseofulvin," and Dr. Perlmutter's "Surgical Treatment of the Extrapyramidal Disorders." Dr. Sackett is chairman of the Subcommittee on Scientific Exhibits of the Academy.

The five day Seminar on Care of Premature Infants will be held May 16-20 at the Premature Demonstration Center in Jackson Memorial Hospital at Miami. Speakers will include personnel of the Center, faculty members of the Department of Pediatrics, University of Miami School of Medicine, and special lecturers from the Dade County Medical Association. The course carries 35 hours credit in Category I. Information is available from the Bureau of Maternal and Child Health, Florida State Board of Health, P. O. Box 210, Jacksonville 1.

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1. Pomeranze, J. et al.: J.A.M.A. 171:252, Sept. 19, 1959. 2. Walker, R. S.: Brit. M J. 2:405, 1959. 3. Odell, W. D., et al.: A.M.A. Arch. Int. Med. 102:520, 1958. 4. Pearlman, W.: Phenformin Symposium, Houston, Feb. 1959. 5. Lambert, T. H.: ibid. 6. Skillman, T. G., et al.: Diabetes 8:274, 1959. 7. Sugar, S. J. N., et al.: Med. Ann. Dist. Columbia 28:426, 1959.

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1. Kestler, O.: In The Pharmacology and Clinical Usefulness of Carisoprodol, Wayne State University Press, Detroit, 1959. 2. Berger, F. M.; Kletzkin, M.; Ludwig, B. J.; Margolin, S., and Powell, L. S.: J. Pharm. Exp. Ther. *127*:66 (Sept.) 1959. 3. Spears, C. E. and Phelps, W. M.: Arch. Pediat. *76*:287 (July) 1959. 4. Phelps, W. M.: Arch. Pediat. *76*:243 (June) 1959. 5. Friedman, A. P.; Frankel, K., and Fransway, R. L.: Papers presented at Scientific Meeting, New York State Society of Industrial Medicine, Inc., New York, Sept. 30, 1959. 6. Kuge, T.: Unpublished reports. 7. Ostrowski, J. P.: Orthopedics *2*:7 (Jan.) 1960.

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1. Lippmann, O.: Arch. Ophth. **57**:339, March 1957
2. Gordon, D.M.: Am. J. Ophth. **46**:740, November 1958.

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1. Cook, J.E., Briggs, G.W., and Hindley, F.W.: Chronic Amebiasis and the Need for a Diagnostic Profile, Am. Pract. and Dig. of Treat. *6*:1821 (Dec., 1955).

2. Rinehart, R.E., and Marcus, H.: Incidence of Amebiasis in Healthy Individuals, Clinic Patients and Those with Rheumatoid Arthritis, Northwest Med., *54*:708 (July, 1955).

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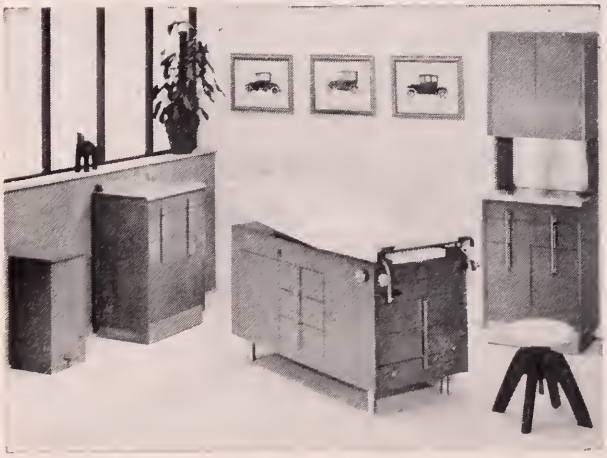

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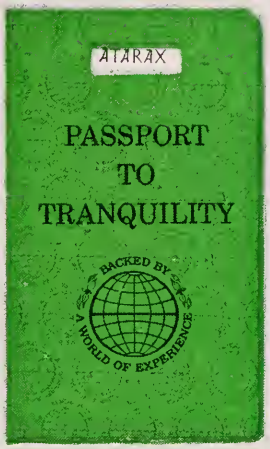

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IN HYPEREMOTIVE ADULTS does not impair mental acuity	"...especially well-suited for ambulatory neurotics who must work, drive a car, or operate machinery." Ayd, F. J., Jr.: New York J. Med. **57**:1742 (May 15) 1957.	Garber, R. C., Jr.: J. Florida M. A. **45**:549 (Nov.) 1958. Menger, H. C.: New York J. Med. **58**:1684 (May 15) 1958. Farah, L.: Internat. Rec. Med. **169**:379 (June) 1956.

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1. Boger, W. P.; Strickland, C. S., and Cylfe, J. M.: Antibiotic Med. & Clin. Ther. 3:378 (Nov.) 1956. 2. Boger, W. P.: In: Antibiotic Annual 1958-1959, Medical Encyclopedia, Inc., New York. 1959, p. 48. 3. Sheth, U. K.; Kulkarni, B. S., and Kamath, P. G.: Antibiotic Med. & Clin. Ther. 5:604 (Oct.) 1958. 4. Anderson, P. C., and Wissinger, H. A.: U. S. Armed Forces M. J. 10:1051 (Sept.) 1959.

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OBITUARIES

Julius C. Davis

Dr. Julius C. Davis of Quincy was stricken with a heart attack at his home on Feb. 26, 1960, and died shortly thereafter in the Gadsden County Hospital. He was 73 years of age.

The eldest of five sons of Zachary Clingman Davis and Lora Jane Noland Davis, Dr. Davis was born on June 27, 1886, in Waynesville, N. C. Upon graduation from high school in Clyde, N. C., he attended Carson-Newman Business College in Jefferson City, Tenn., and later Davidson College in Davidson, N. C. For his medical training he chose the Atlanta School of Medicine, now incorporated in Emory University, and was graduated with highest honors from that institution in 1909. The day after graduation he passed the Georgia Medical Board examination and later passed the examinations in Florida and North Carolina.

Prior to locating in Florida, Dr. Davis engaged in the private practice of medicine for two years in Candler, N. C. In 1911, he took over

the practice of Dr. Francis Phillips in Quincy and continued to practice there for almost half a century. Surgery was his specialty. Locally, he was for many years active in social and civic affairs. He was a member and past president of the Rotary Club, holding honorary life membership in recent years. He was a member of the Elks Club and of the Quincy Golf Club, later combined with the Sawano Country Club, of which he was a charter member. A Mason and a Shriner, he served at one time as Grand Worshipful Master and once as Eminent Commander of the Knights Templar. He held membership in the Centenary Methodist Church of Quincy.

In World War I, Dr. Davis served as a first lieutenant in the Army Medical Reserve Corps. During World War II, he was chairman of the Medical Advisory Committee for the state. In the early thirties he became medical examiner for the Veterans Administration and through the years was retained as physician to the Veterans Administration under orders from the Bay Pines Facility. In the late thirties, he was medical referee for the Florida Industrial Commission, and in 1938 was appointed by the Governor as chairman of the Merit System Board.

A leader in organized medicine in the state, Dr. Davis in 1913 was one of the founders of the Leon-Gadsden County Medical Society. This society was reorganized in 1920 as the Second District Medical Society, with Dr. Davis as president. Throughout the years he continued to be active in his county society, now the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society.

He rendered distinguished service to the Florida Medical Association, of which he was a life member, having been affiliated with the Association for 49 years. He served as second vice president in 1913-1914, third vice president in 1923-1924, and president in 1929-1930. For a number of years he was chairman of the Association's Committee on Legislation and Public Policy.

For 14 years Dr. Davis was a member of the Florida State Board of Medical Examiners. In

(Continued on page 1450)

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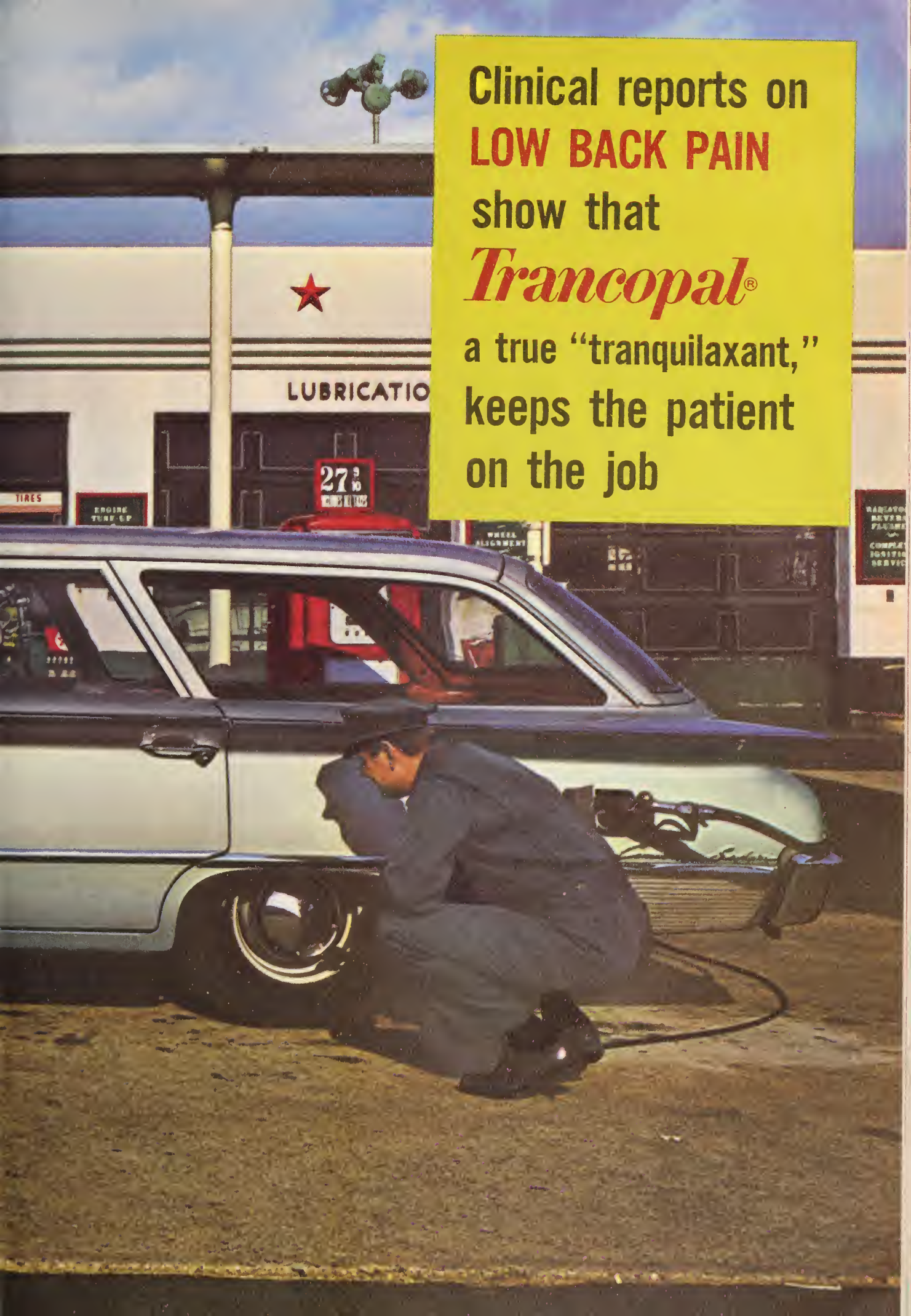
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ences: 1. Lichtman, A. L.: Kentucky Acad. Gen. Pract. J. 4:28, Oct., 1958. 2. Mullin, W. G., and Epifano, Leonard: Am. Pract. & Digest Treat. 43, Oct., 1959. 3. Gruenberg, Friedrich: Current Therap. Res. 2:1, Jan., 1960. 4. Shanaphy, J. F.: Current Therap. Res. 1:59, Oct., 1959. nz, S. E.: J. Indiana M. A. 52:1134, July, 1959. 6. Stough, A. R.: J. Oklahoma M. A. 52:575, Sept., 1959.

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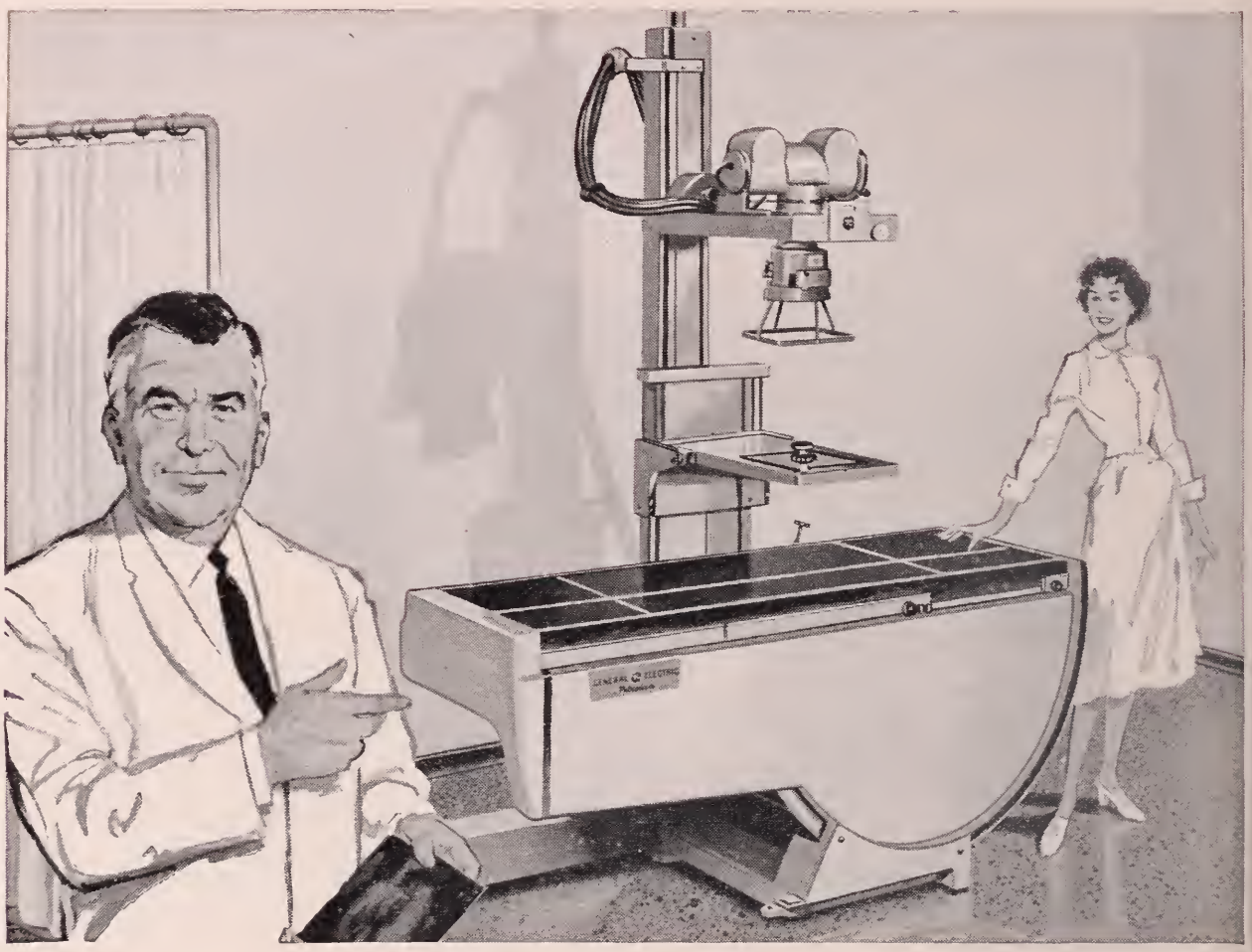

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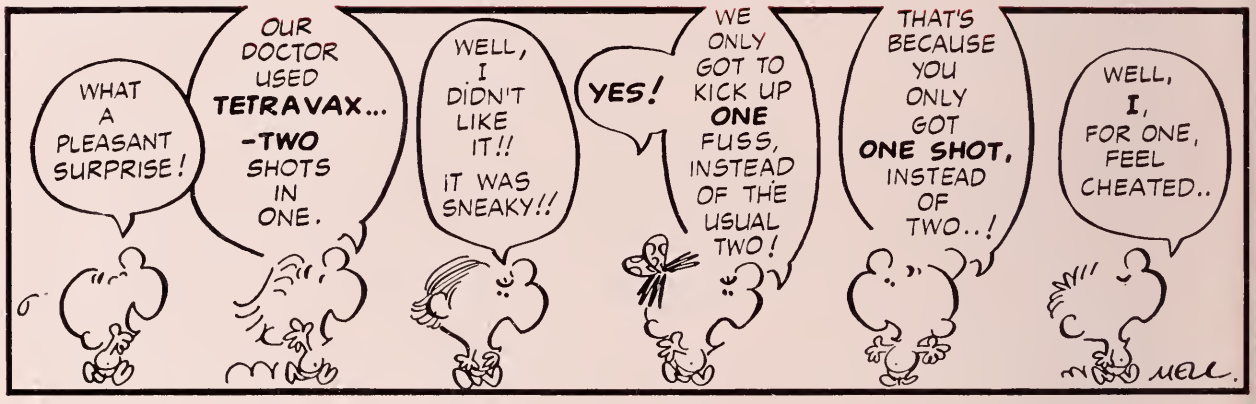

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1. Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: *J. Am. Pharm. A. (Scient. Ed.)* 48:380, July, 1959. 2. Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: *J. Am. Pharm. A. (Scient. Ed.)* 48:384, July, 1959.

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Ferric Pyrophosphate (Soluble)	250 mg.
Iron (as Ferric Pyrophosphate)	30 mg.
Sorbitol	3.5 Gm.
Alcohol	.75%

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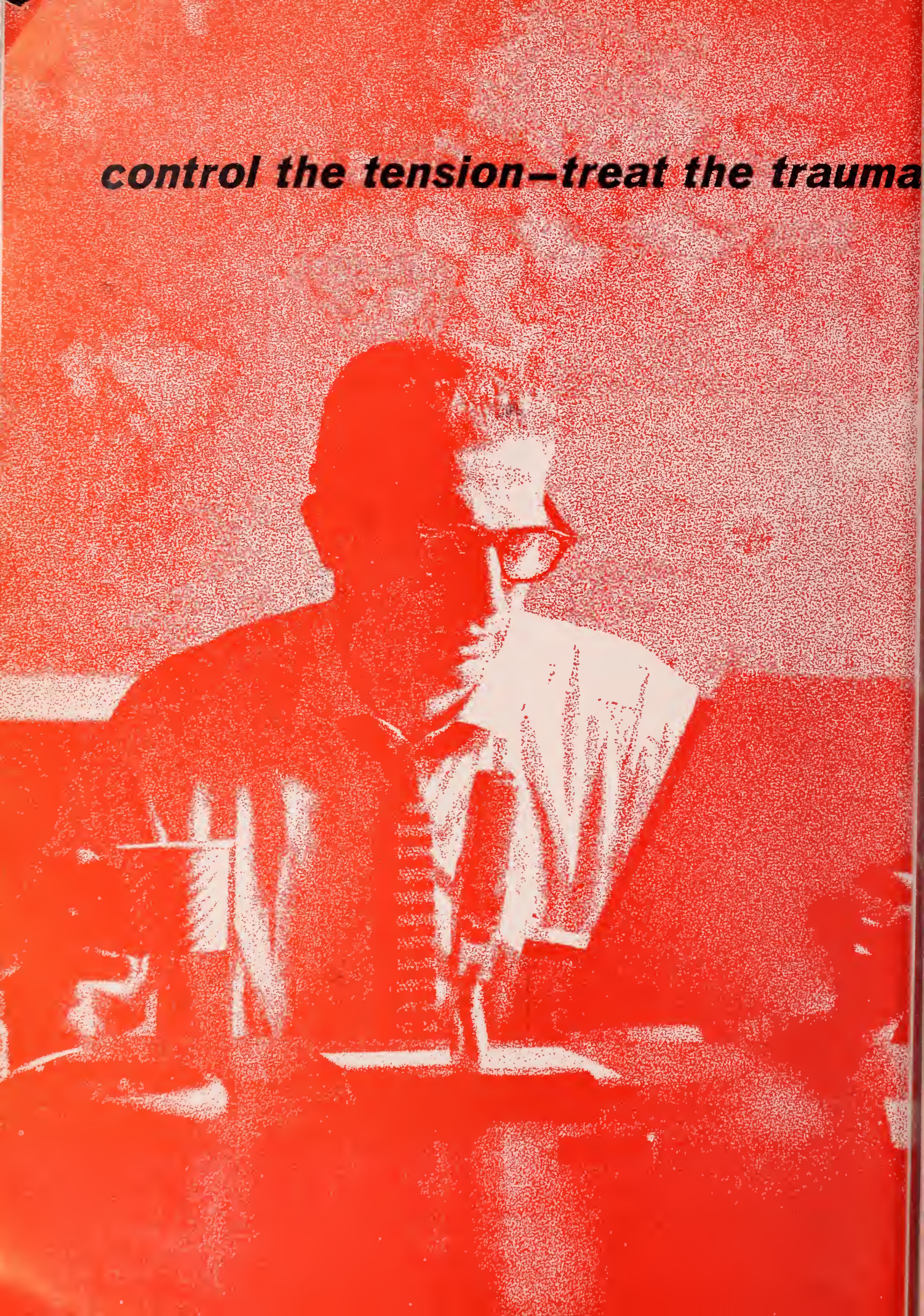
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Adjust to patient response.

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(Continued from page 1438)

1938-1939 he served as its president. Over the years he had three special interests to which he devoted much time and enthusiasm: the Gadsden County Hospital, public health in Florida, and the Florida State Hospital. He was a founder of the original hospital in the county and served as business manager and medical director from 1920 to 1923. Later he contributed his substantial interest to the county to make possible the building of the present Gadsden County Hospital. He worked actively to promote public health in Florida and was instrumental in organizing the Gadsden-Liberty County Health Department. For many years he served the Florida State Hospital in various advisory capacities and for some time was clinical director of surgery. For a time he also was a visiting surgeon for the Florida A. & M. College Hospital.

At the time of the initial planning of the College of Medicine of the University of Florida and the J. Hillis Miller Health Center in 1953, Dr. Davis served as an adviser to the University. Since that time he had continued to serve the College of Medicine in an advisory capacity.

Dr. Davis was a member and a past president of the Chattahoochee Valley Medical and Surgical Association. He was active in the Southern Medical Association, serving as a vice president at one time, and was one of the founders of the Southeastern Surgical Congress, of which he was a counselor for years and first vice president in 1957. For more than a quarter of a century he was a surgeon for the Seaboard Airline Railroad Company and in 1955 was president of the Florida Railway and Industrial Surgeons. A fellow of the American College of Surgeons, he served on the Florida credentials committee for some 30 years and in 1958 was president of the Florida chapter of that organization. From 1939 to 1955 he was a state regent for the International College of Surgeons. In 1936 he was president of the Emory University Medical Alumni Associations and two years later president of the Florida Medical Alumni. He was throughout his professional career affiliated with the American Medical Association and he made a number of significant contributions to medical literature.

Quincy and Gadsden County residents honored Dr. Davis on April 30, 1959, with a "Dr. J. C. Davis Day," in observance of his 50 years of service to the community and to the medical profession. Distinguished colleagues and officials

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from Florida and Georgia joined hundreds of his local friends and patients in paying tribute to this exemplary citizen and eminent practitioner of the art and science of medicine.

Dr. Davis is survived by his widow, Mrs. Bonnie Jean Marquardt Davis, of Quincy; two sons, Julian C. Davis, of Chattahoochee, and L. P. Davis, of Orlando; a daughter, Miss Lora Frances Davis, of Houston, Texas; a brother, J. Wiley S. Davis, of San Juan, P. R.; and six grandchildren.

BOOKS RECEIVED

Synopsis of Treatment of Anorectal Diseases. By Stuart T. Ross, M.D., F.A.C.S., F.I.C.S. Pp. 240. Price, $6.50. St. Louis, The C. V. Mosby Company, 1959.

This book was designed especially to help the general practitioner, who treats most of the patients with anorectal difficulties, and also to serve as a guide for the medical student, the intern and the resident. In view of this aim, the book is streamlined to present essentials shorn of extraneous verbiage in a format that is easily handled and carried. Bibliography, statistics, and extensive discussion of etiology, pathology, and major surgical technics have been omitted. Included, however, are the essentials of diagnosis and treatment of all the anorectal diseases. Since all proper diagnosis and therapy are based on a knowledge of anatomy, a concise description of the anorectal structures is also included, as well as a brief description of the common symptoms and methods of taking a proctologic history and performing a proctologic examination.

Insulin Treatment in Psychiatry. *Proceedings of the International Conference on the Insulin Treatment in Psychiatry Held at the New York Academy of Medicine October 24 to 25, 1958.* Edited by Max Rinkel, M.D. and Harold E. Himwich, M.D. Pp. 386. Price, $5.00. New York, Philosophical Library, 1959.

This volume includes the papers and ensuing discussions presented at the October 1958 International Conference on the Insulin Treatment in Psychiatry. The list of authors and panel members shows that the most distinguished proponents and opponents of the insulin shock treatment were well represented. The purpose of the conference was to assess the value of insulin treatment of psychoses, to provide a global view of the use of such treatment, to learn about its failures as well as its successes, and to compare its results with those of other therapies. The views of the contributors and discussants and the evidence on which they are based demonstrate, in the opinion of the editors, that insulin therapy is not outmoded and is still essential in psychiatry. It remains the most effective method of curing schizophrenic patients.

Ciba Foundation Symposium on the Biosynthesis of Terpenes and Sterols. Edited by G. E. W. Wolstenholme, O.B.E., M.A., M.B., B.Ch., and Maeve O'Connor, B.A. Pp. 311. Illus. 102. Price, $8.75. Boston, Little, Brown and Company, 1959.

The great forward steps in recent years in the study of the biosynthesis of terpenes and sterols have been aided mostly by the introduction of isotope tracers fed to

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plants and animals and by the discovery of mevalonic acid, the most significant discovery made in the series discussed here. This symposium will be of interest not only to those working in the field but also to biochemists, physiologists, and pathologists concerned with the general aspects of the subject. The program chairman commented that it will "be quoted for many years to come and be regarded as a landmark in the progress of the subject." Subjects dealt with include biogenesis and transformation of squalene, discovery and elucidation of mevalonic acid, alterations of cholesterol biosynthesis in liver cell fractions from rats in various experimental conditions, the enzymic synthesis of branched-chain acids, the mechanisms of a rearrangement occurring during biosynthesis of cholesterol, biosynthesis of squalene and of cholesterol from mevalonic acid, biogenesis of terpenes in moulds and higher plants and the biosynthesis of carotenoids by micro-organisms.

The Family Medical Encyclopedia. By Justus J. Schifferes, Ph.D. Pp. 617. Price, $4.95. Boston, Little, Brown and Company, 1959.

This simple comprehensive family guide to health and medical care is designed to serve in the threefold capacity of an authoritative health encyclopedia, an illustrated medical dictionary and an indispensable manual of first aid. It answers the most common and pressing questions of the laity about hospitals, modern medicine, health and disease. It is written in words which are easy to understand. The subjects are arranged from A to Z as in a dictionary and they include lucid definitions of those medical terms most frequently used by physicians and nurses when talking to the patient or to the family. In addition, there are comprehensive articles on the most common diseases: arthritis, cancer, diabetes, heart trouble, and many others; on the care and functioning of the body; on preparing oneself to go to the hospital; and on health in childhood and old age. Such entries as Health Insurance and Blue Cross cover the economic aspects of medical and hospital care, and the sequence of topics of diet, the digestive system, fat, vitamins and weight, including a separate calorie counter, are particularly helpful. This is a Health Education Council book, and the author has been director of that organization since 1945. He is a well known author and sometime editor or publisher of five medical journals.

Trauma. By Harrison L. McLaughlin, M.D., with the collaboration of 19 authorities. Pp. 794. Illus. 390. Price, $18.00. Philadelphia, W. B. Saunders Company, 1959.

This book presents management for every type of injury likely to be inflicted on the human organism. The various soft tissue injuries and fractures the body may suffer are taken up here one by one. Etiology, pathology and prognosis are presented in vivid detail. For each injury there are precise directions for immediate care, supportive therapy and long range definitive correction. Athletic injuries are described. Uncommon injuries are included in sufficient detail to warn of treatment pitfalls. A concise introduction outlines broad principles applying to handling of all injury, and a wealth of illustration shows pertinent anatomy and the detailed steps of management. Dr. McLaughlin is Professor of Clinical Orthopedic Surgery at the College of Physicians and Surgeons of Columbia University, and with one exception the contributing authors are or have been members of the Attending Staff of the Columbia-Presbyterian Medical Center in New York City, and of the Faculty of the College of Physicians and Surgeons of Columbia University. The general surgeon, general practitioners, orthopedists and neurosurgeons will find this book particularly helpful.

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Clinical Director

Care of the Patient With a Stroke. *A Handbook for the Patient's Family and the Nurse.* By Genevieve Waples Smith, R.N., M.A. Pp. 148. Price, $2.75. New York, Springer Publishing Company, Inc., 1959.

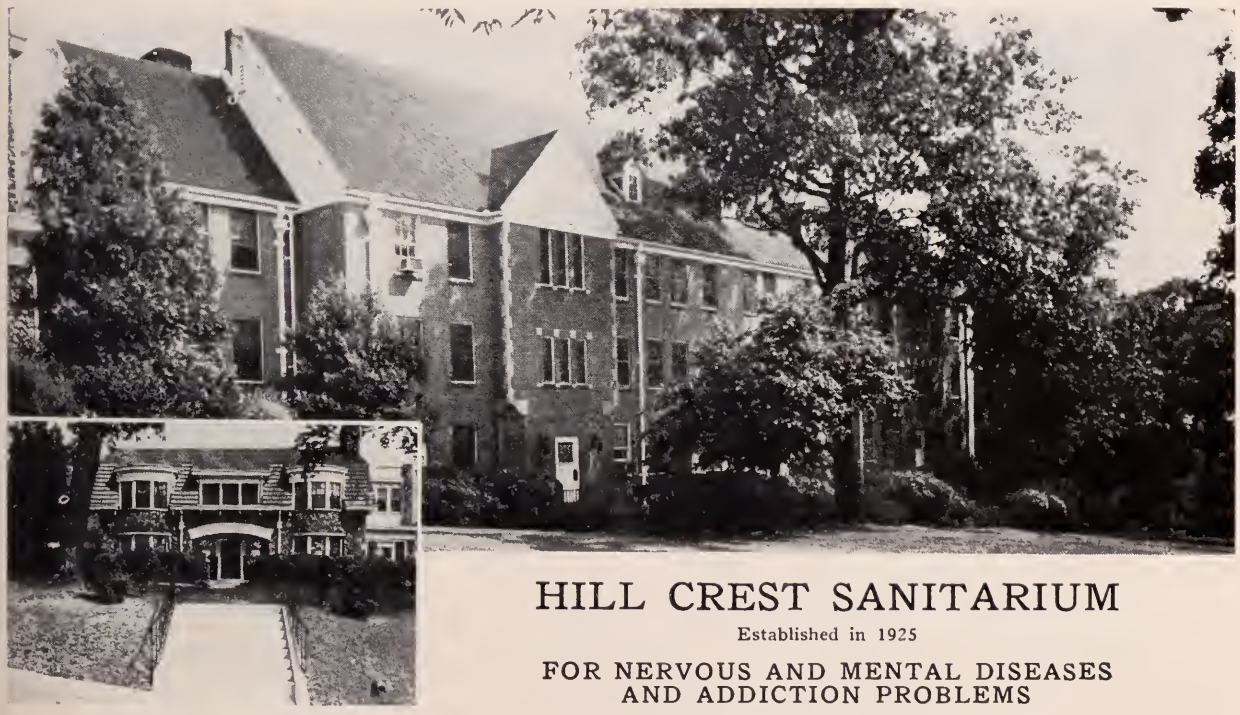
The author, an experienced nurse, wrote this book to guide anyone who must care for a patient who has had a stroke, and she makes it clear that "home" is the best place for such a patient. Because there were many questions about his care she could not answer when her husband had a stroke, she put in this handbook the necessary and practical things she learned which provide guidance from the day the patient comes home until he reaches the highest level of rehabilitation possible for him. Throughout the book and in one special chapter, she also points out the psychological problems encountered by the patient and his family and makes many suggestions for solving these problems.

Surgical Pathology. By Lauren V. Ackerman, M.D., in Collaboration With Harvey R. Butcher, Jr., M.D. Ed. 2. Pp. 1096. Illus. 1114. Price, $15.00. St. Louis, The C. V. Mosby Company, 1959.

This comprehensive volume is written for the medical student as well as those physicians who are daily intimately concerned with surgical pathology. Their number includes of necessity not only the surgeon and the pathologist but also those physicians in other fields who are affected by its decisions, such as the radiologist and the internist. Gross pathology is stressed throughout with an attempt to correlate the gross findings with the clinical observations. This second edition has been entirely revised; new illustrations have been added, and the references have been brought up to date. To the authors' knowledge this is the first time a pathologist and a surgeon have collaborated on a book on surgical pathology —an endeavor which should lead to a better understanding of this branch of pathology. Clinical pathologic correlation has been strengthened, and disease processes as they affect the living patient have been clarified. Dr. Ackerman is Professor of Surgical Pathology and Pathology and Dr. Butcher, who edited the entire revision with him and wrote the section on Wound Healing and the chapter on Vessels, is Associate Professor of Surgery at Washington University School of Medicine in St. Louis. They have combined their skill and knowledge to produce a book which bridges the gap between autopsy pathology and the living patient and helps translate diagnosis into action.

A Doctor's Life of John Keats. By Walter A. Wells, M.D. Pp. 247. Price, $3.95. New York, Vantage Press, 1959.

In this fascinating biography, a doctor reveals Keats' life as a man of medicine, then as a patient. The illness that covered his entire career as a poet was severe . . . and the wonder of it is that his creative powers increased as his physical powers diminished. His masterpieces were composed when his bodily resistance was reaching its lowest ebb. In these pages a wholly sympathetic portrait of a genius in whom psychosomatic phenomena were conspicuously present emerges under the skilled hand of the author. One sees a poet tortured by a doomed love affair; a young apothecary apprentice preparing pills and powders, applying bandages, helping set broken bones; a slight youth standing on tiptoe, not upon a little hill to see "the sweet buds, with their modest pride pulling droopingly," but in Guys Hospital, London, beside a dissecting table, to be in a better position to wield the scalpel on a gruesome corpse, for reasons anatomical. In considering Keats, Dr. Wells has considered also the cause and nature of genius, the mysterious "intuitive perception" which comes only to a few. The book is of particular interest to physicians, but is by no means for them only. Written by a distinguished medical author and otolaryngologist of Washington, D. C., it is a memorable study of a great poet whose life as a disciple of Aesculapius is far too little known.



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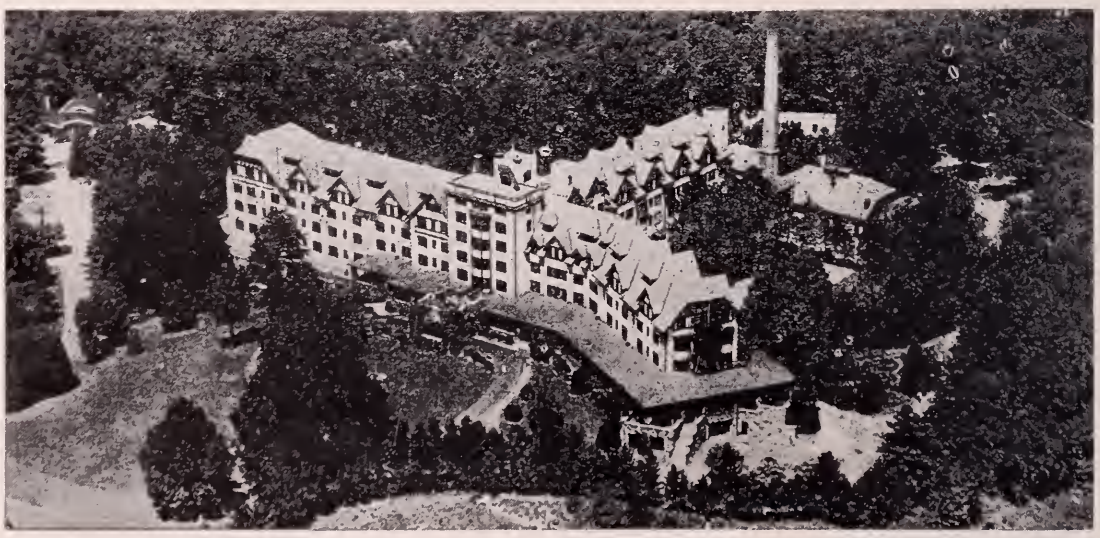

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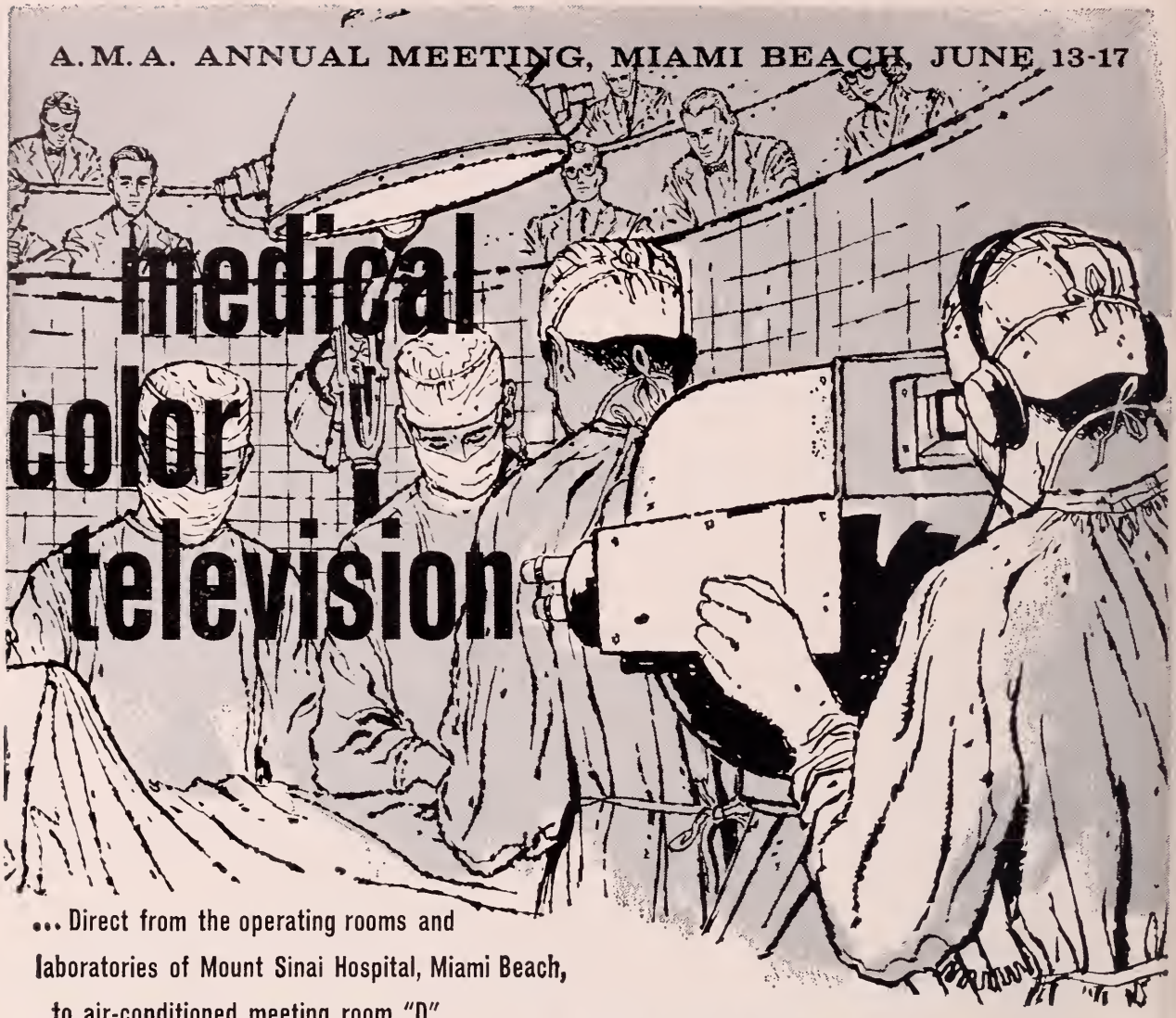

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See the complete program in the April 16 J.A.M.A. Advance hotel and meeting registration forms appear in that issue and in the first issues of J.A.M.A. each month.

HERE ARE PROGRAM SAMPLES OF THREE TV SYMPOSIA:

New Techniques in the Differential Diagnosis of Jaundice

MONDAY AFTERNOON, JUNE 13

Moderator: WINSTON K. SHOREY, Miami.
Panelists: RICHARD C. CLAY, FREDDIE P. GARGANO, Miami; and ALLAN KAPLAN, Miami Beach.
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Modern Diagnostic Cardiovascular Techniques

MONDAY AFTERNOON, JUNE 13

Moderator: VICTOR H. KUGEL, Miami Beach.
Participants: PHILIP SAMET, JACK WIDRICH, Miami Beach; FRANCISCO A. HERNANDEZ, WILLIAM P. MURPHY, JR., and LEONARD S. SOMMER, Miami.

Surgical Aspects of Rheumatoid Arthritis and Similar Lesions

TUESDAY AFTERNOON, JUNE 14

Moderator: EDWARD W. CULLIPHER, Miami.
Panelists: LEE RAMSEY STRAUB and RICHARD H. FREYBERG, New York, J. LEONARD GOLDNER, Durham, N. C.
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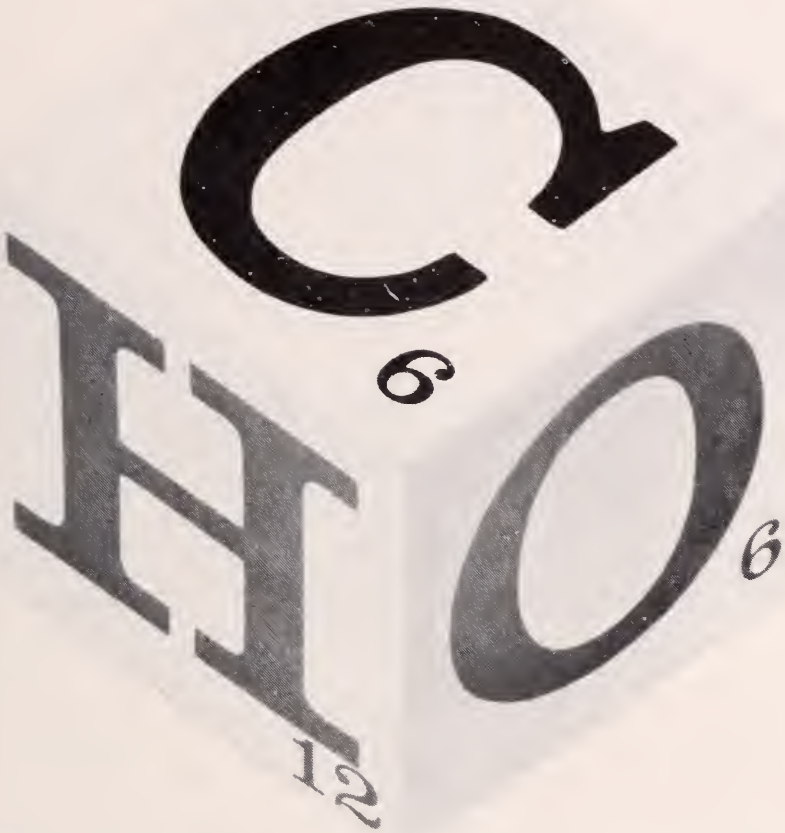
SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	TOTAL MEMBERS Associate	Active
Alachua	Eugene H. Cummings, Gainesville	Richard E. Perry, Gainesville	2nd Tues.		78
** Bradford, Gilchrist, Union*					
Bay	Donald H. Anderson, Panama City	John L. Fishel, Panama City	2nd Tues.		33
Brevard	Cyrus E. Warden, Melbourne	Spencer C. Manrodt, Melbourne	1st Tues.	2	71
Broward	Anthony C. Galluccio, Hollywood	Frederick W. Fisher, Ft. Lauderdale	4th Tues.	30	262
Charlotte	Robert H. Shedd, Punta Gorda	Carl N. Reilly, Punta Gorda	2nd Tues.		5
Collier	Loral F. Gwaltney, Naples	Ethel H. Trygstad, Naples	4th Tues.		14
Columbia	Harry S. Howell, Lake City	Thomas H. Bates, Lake City	3rd Wed.		12
** Baker*					
Dade	Franklin J. Evans, Coral Gables	DeWitt C. Daughtry, Miami	1st Tues.	53	996
DeSoto-Hardee-Glades	Harold S. Agnew, Arcadia	Elmer J. Schmierer, Arcadia	1st Tues.		14
Duval	Floyd K. Hurt, Jacksonville	Albert D. Rood, Jacksonville	1st Tues.	5	364
** Clay*					
Escambia	William J. Overman, Warrington	Howard E. Herring Jr., Pensacola	2nd Tues.	1	118
Franklin-Gulf	Photis J. Nichols, Apalachicola	Joseph P. Hendrix, Port St. Joe	Last Wed.		6
Highlands	Hubert W. Coleman, Avon Park	Samuel A. King, Avon Park	3rd Mon.	1	13
Hillsborough	Linus W. Hewit, Tampa	Frank A. Massari, Tampa	1st Tues.	1	253
Indian River	Charles F. Rattray Jr., Vero Beach	Walter W. McCorkle, Vero Beach	2nd Tues.	2	14
Jackson-Calhoun	William R. Wandeck, Marianna	Francis M. Watson, Marianna	Quarterly		17
Lake	Arthur P. Buchanan, Leesburg	Thomas D. Weaver, Clermont	1st Wed.	3	36
** Sumter*					
Lee-Hendry	George D. Hopkins II, Ft. Myers	Leland K. Glenn, Ft. Myers	3rd Mon.		39
Leon-Gadsden-Liberty-Wakulla-Jefferson	Edson J. Andrews, Tallahassee	David J. McCulloch, Tallahassee	1st Mon.	7	74
Madison	Julian M. Durant, Madison	Thomas G. Bouland Jr., Madison	1st Tues.	1	6
Manatee	Willett E. Wentzel, Bradenton	John A. Shively, Bradenton	2nd Tues.		40
Marion	Robert E. Thompson, Ocala	William C. Butscher, Ocala	3rd Tues.		34
** Levy*					
Monroe	Walter R. McCook, Key West	Joseph L. G. Lester Jr., Key West	1st Thurs.		15
Nassau	David D. Bennett Jr., Callahan	Cecil B. Brewton, Fernandina Beach	1st Thurs.	2	10
Orange	W. Dean Steward, Orlando	Robert W. Curry, Orlando	3rd Wed.	22	232
** Osceola*					
Palm Beach	Willard F. Ande, W. Palm Beach	Herman Baxt, W. Palm Beach	4th Mon.	21	183
Pasco-Hernando-Citrus	William H. Walters Jr., Lacoochee	W. Wardlaw Jones, Dade City	2nd Thurs.	1	21
Pinellas	Chas. L. Farrington, St. Petersburg	Whitman C. McConnell, St. Petersburg	1st Mon.	13	311
Polk	Charles Larsen Jr., Lakeland	Clarence L. Anderson, Lakeland	2nd Wed.	10	133
Putnam	Roy E. Campbell, Palatka	Norman B. Edgerton, Palatka	2nd Tues.		15
St. Johns	S. Raymond Cafaro, St. Augustine	Joseph A. Shelley, St. Augustine	3rd Tues.		19
St. Lucie-Okeechobee-Martin	Joseph H. Batsche, Fort Pierce	Maltby F. Watkins, Ft. Pierce	3rd Thurs.		29
Sarasota	James E. Kicklighter, Sarasota	Thomas G. Dickinson, Sarasota	2nd Tues.	3	92
Seminole	Edwin Epstein, Sanford	Robert J. Smith, Sanford	2nd Tues.	1	18
Suwannee-Hamilton-Lafayette	Frederick T. Mickler Jr., Jasper	Irby H. Black, Live Oak	1st Sat.		10
Taylor	John H. Parker Jr., Perry	John A. Dyal Jr., Perry	Last Fri.		5
** Dixie*					
Volusia	Jas. J. Cunningham, New Smyrna Bch.	John J. Cheleden, Daytona Beach	2nd Tues.	3	102
** Flager*					
Walton-Okaloosa-Santa Rosa	Joseph C. Wilson, Ft. Walton Beach	Wm. W. Thompson, Ft. Walton Beach	3rd Tues.	4	33
Washington-Holmes	Walter H. Shehee, Chipley	L. H. Paul, Bonifay	Quarterly	1	4
				187	3,731
			Total	187	3,918



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Symptoms	No. of Patients	Per cent of total group
Polyuria	93	84.5
Polydipsia	89	81.0
Weight loss	47	42.7
Polyphagia	28	25.4
Anorexia	16	14.5
Lethargy	14	12.7
Enuresis	7	6.4
Vomiting	5	4.5
Irritability	3	2.7
"Craving for sweets"	3	2.7
"Sticky diaper"	3	2.7
"Strong odor to urine"	2	1.8
Glycosuria	2	1.8
Hypoglycemia	2	1.8
Personality change	1	0.9
Boils	1	0.9
Headache	1	0.9
Abdominal cramps	1	0.9

Adapted from Traisman, H. S.; Boehm, J. J., and Newcomb, A. L.*

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1. Goddard, E.S.: in *Trifluoperazine, Further Clinical and Laboratory Studies*, Philadelphia, Lea & Febiger, 1959.

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DMINISTRATION AND DOSAGE

(pressed in terms of base)

ndition	Dosage (daily, in divided doses)	Duration of Therapy
ectious Diarrheas cillary and nspecific)	*Adults:* 35 to 50 mg/Kg; up to 100 mg/Kg in severe cases.	Up to 7 days
	Children: 50 mg/Kg; up to 100 mg/Kg in severe cases.	Up to 7 days
stinal Amebiasis te, subacute, onic)	*Adults:* 0.75 to 1.5 Gm.; larger doses when required.	5 days
	Children: 22 mg/Kg; larger doses when required.	5 days
operative S pression of stinal Flora	*Adults:* 2 Gm.	4 days
atic Coma	*Adults:* up to 6 Gm., depending on degree of hepatic insufficiency and response of patient.	See literature

SDE EFFECTS: Since HUMATIN by the oral route is tually nonabsorbed in the gastrointestinal tract, even h exceptionally high doses, systemic toxicity has not been problem in clinical use.[2,3,5-8] However, when doses in ess of 2 Gm. per day are given for more than three days, se stools may develop; on doses of from 4 to 6 Gm. daily, moderately severe diarrhea has been reported in some patients. No other indications of toxicity have been observed.

SUPPLIED: HUMATIN (paromomycin, Parke-Davis) is available as the sulfate in Kapseals,® each containing 250 mg. of base, in bottles of 16. Literature supplying details of dosage and administration available on request.

REFERENCES: (1) Coffey, G. L., *et al.*: *Antibiotics & Chemother.* 9:730, 1959. (2) Personal Communications to the Department of Clinical Investigation, Parke, Davis & Company, 1959. (3) Godenne, G. D.: Paromomycin in diarrheas of infants and children, Antibiotics Annual 1959-1960, New York, Medical Encyclopedia Inc., in press. (4) McMath, W. F. T., & Hussain, K. K.: *Pub. Health* 73:328, 1959. (5) Courtney, K. O., & Thompson, P. E.: Paromomycin as a therapeutic substance for intestinal amebiasis and bacterial enteritis, Antibiotics Annual 1959-1960, New York, Medical Encyclopedia Inc., in press. (6) Shafei, A. Z.: *Antibiotic Med. & Clin. Therapy* 6:275, 1959. (7) Elias, F. L., & Oliver-Gonzales, J.: *Antibiotic Med. & Clin. Therapy* 6:584, 1959. (8) Carter, C. H.: *Antibiotic Med. & Clin. Therapy* 6:586, 1959. (9) Fast, B. B., *et al.*: *Arch. Int. Med.* **101**:467, 1958. (10) Mackie, J. E., *et al.*: *New England J. Med.* **259**:1151, 1958. (11) Stormont, J. M., *et al.*: *New England J. Med.* **259**:1145, 1958.

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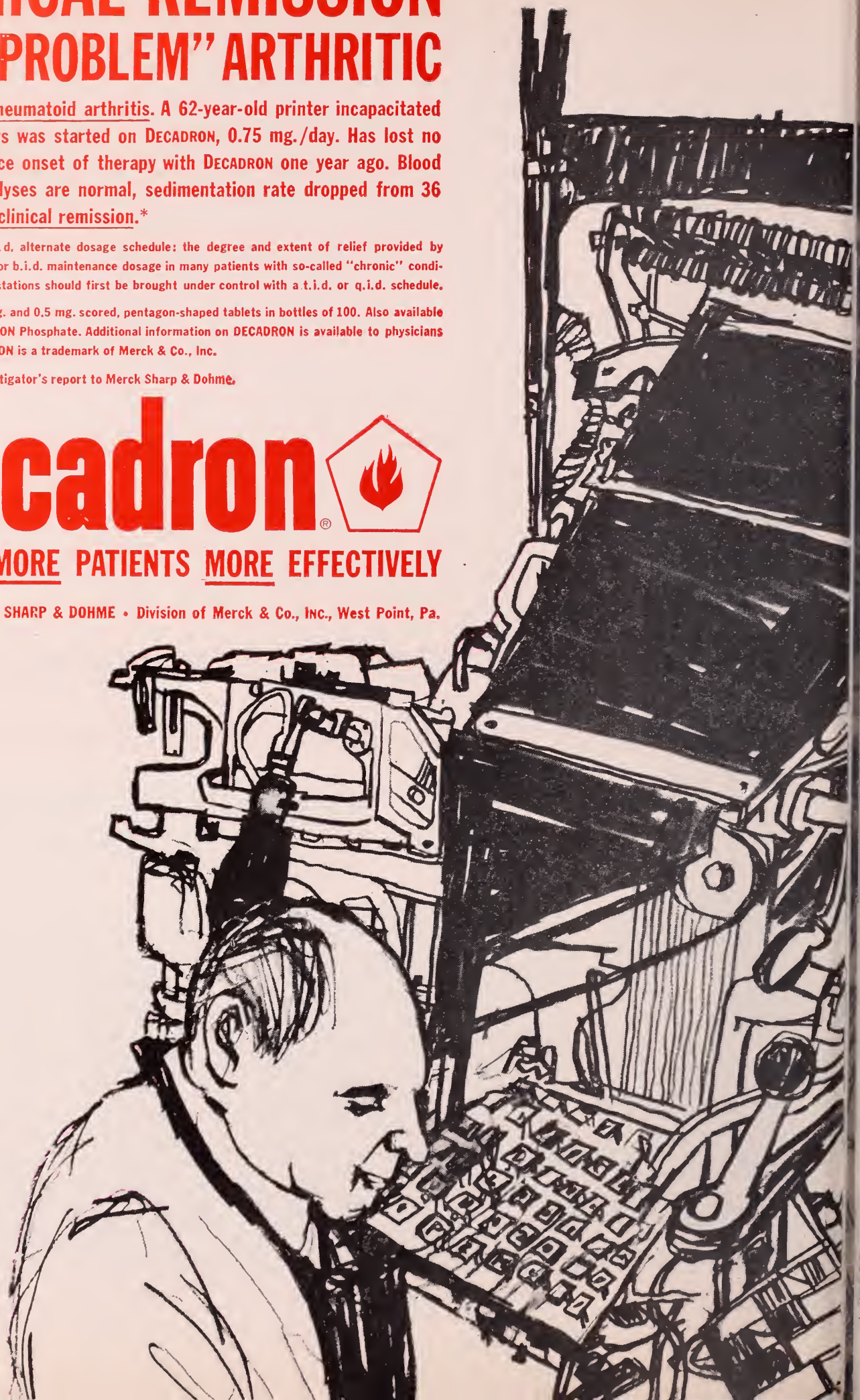

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This Journal is not responsible for the opinions and statements of its contributors.
Owned and published by Florida Medical Association.

Published monthly at Jacksonville, Florida. Price $5.00 a year: single numbers, 50 cents. Address Journal of Florida Medical Association, P.O. Box 2411, 735 Riverside Ave., Jacksonville 3, Fla. Telephone EL 6-1571. Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918. Entered as second-class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida, October 23, 1924.

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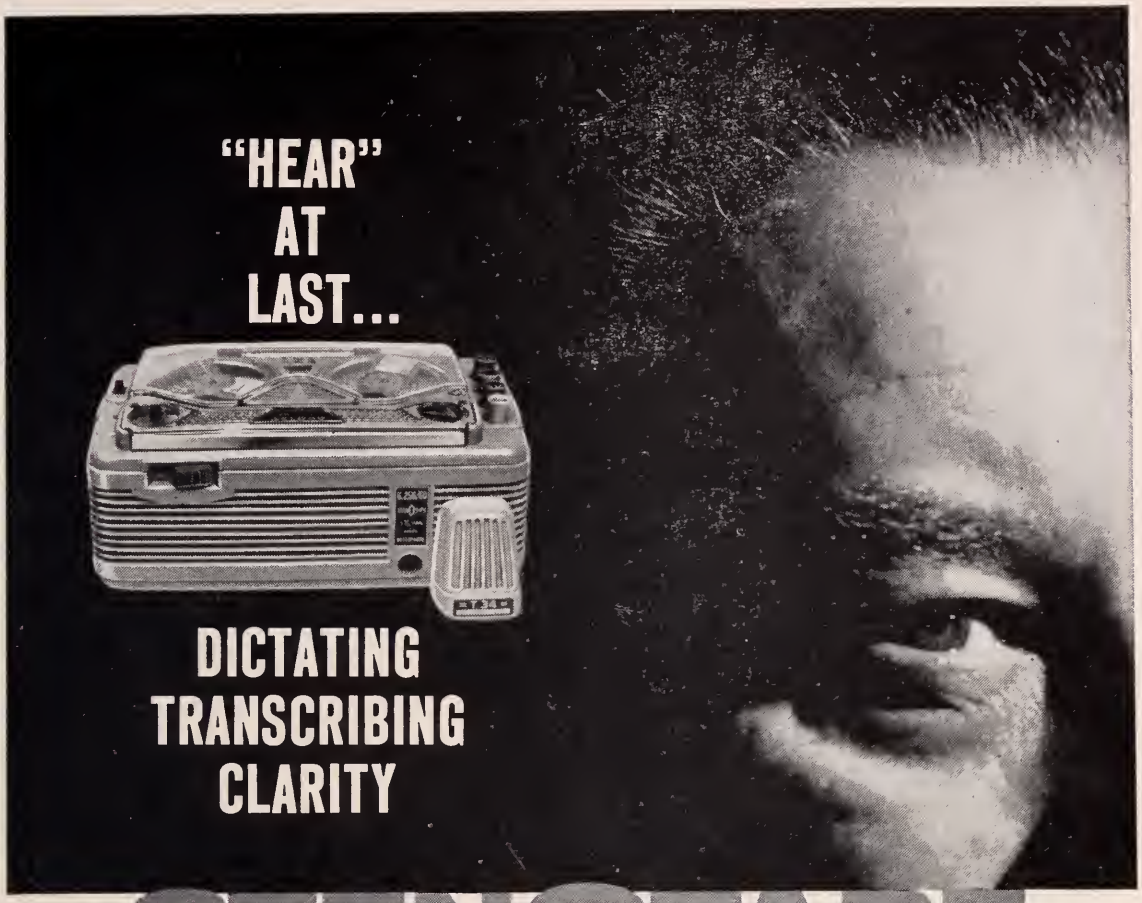

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References: 1. Goodman, L. S. and Gilman, A.: The Pharmacological Basis of Therapeutics, 2nd Ed., New York, Macmillan Company, 1955. 2. O'Reilly, P. O., Demay, M. and Kotlowski, K.: Cholesteremia and Nicotinic Acid. A.M.A. Arch. Int. Med. 100:797-801 (Nov.) 1957.

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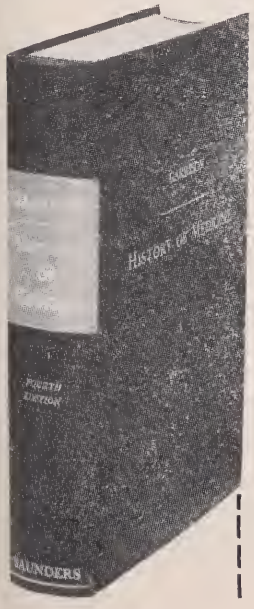

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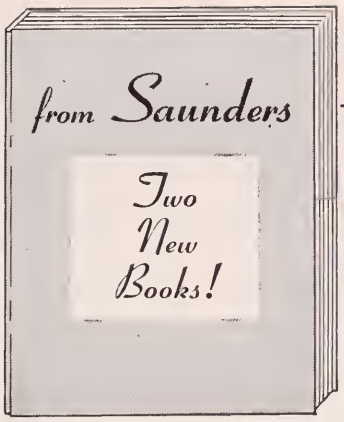

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Ref: Plotz, M.: Modern Management of Obesity, J.A.M.A. 170: 1513-1515 (July 25) 1959.

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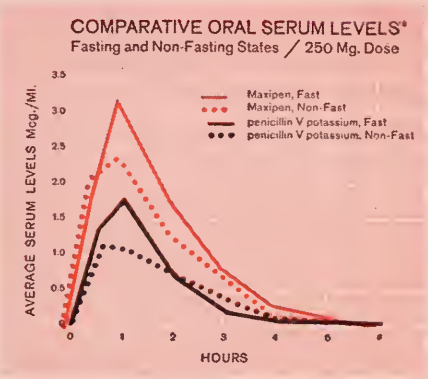

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Thursday, June 23, 1960
The Holiday Inn

***SPRINGFIELD, MISSOURI**
Sunday, June 26, 1960
The Holiday Inn

***ROANOKE, VIRGINIA**
Saturday, July 16, 1960
The Hotel Roanoke

***SANTA ROSA, CALIFORNIA**
Friday, September 16, 1960
The Flamingo Hotel

***KANSAS CITY, KANSAS**
Friday, September 23, 1960
Battenfeld Memorial
Auditorium

HOUSTON, TEXAS
Saturday, September 24, 1960
The Shamrock Hilton Hotel

DEFIANCE, OHIO
Wed., September 28, 1960
Defiance College

PHILADELPHIA, PENN.
Sunday, October 16, 1960
The Sheraton Hotel

***HARTFORD, CONNECTICUT**
Thursday, October 20, 1960
The Statler Hotel

***GREAT FALLS, MONTANA**
Saturday, October 22, 1960
The Rainbow Hotel

ROCHESTER, NEW YORK
Wednesday, October 26, 1960
The Manger Hotel

CHARLESTON, WEST VIRGINIA
Sunday, October 30, 1960
The Daniel Boone Hotel

SIOUX FALLS, SOUTH DAKOTA
Tuesday, November 1, 1960
The Sheraton-Cataract Hotel

***CHARLOTTE, N. CAROLINA**
Thursday, November 3, 1960
The Hotel Charlotte

***CLEVELAND, OHIO**
Wednesday, November 9, 1960
Pick Carter Hotel

***SOUTH BEND, INDIANA**
Friday, November 18, 1960
The Pick-Oliver Hotel

WESTCHESTER COUNTY, N. Y.
Wednesday November 30, 1960
Westchester Country Club

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*Knudsen, E. T., and Rolinson, G. N.: Lancet 2:1105 (Dec. 19) 1959.

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1. Cook, J.E., Briggs, G.W., and Hindley, F.W.: Chronic Amebiasis and the Need for a Diagnostic Profile, Am. Pract. and Dig. of Treat. *6*:1821 (Dec., 1955).

2. Rinehart, R.E., and Marcus, H.: Incidence of Amebiasis in Healthy Individuals, Clinic Patients and Those with Rheumatoid Arthritis, Northwest Med., *54*:708 (July, 1955).

3. Webster, B.H.: Amebiasis, a Disease of Multiple Manifestations, Am. Pract. and Dig. of Treat. *9*:897 (June, 1958).

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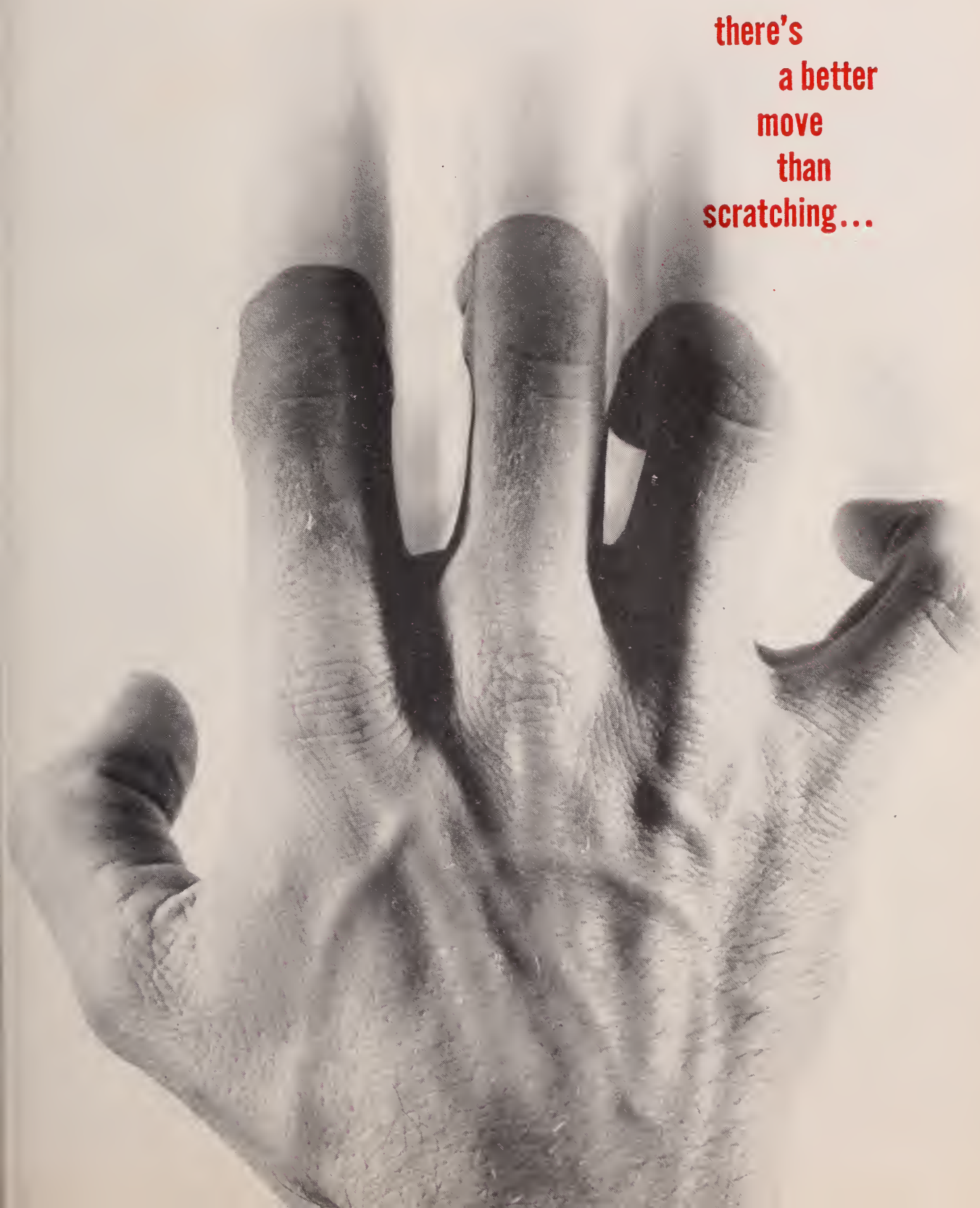

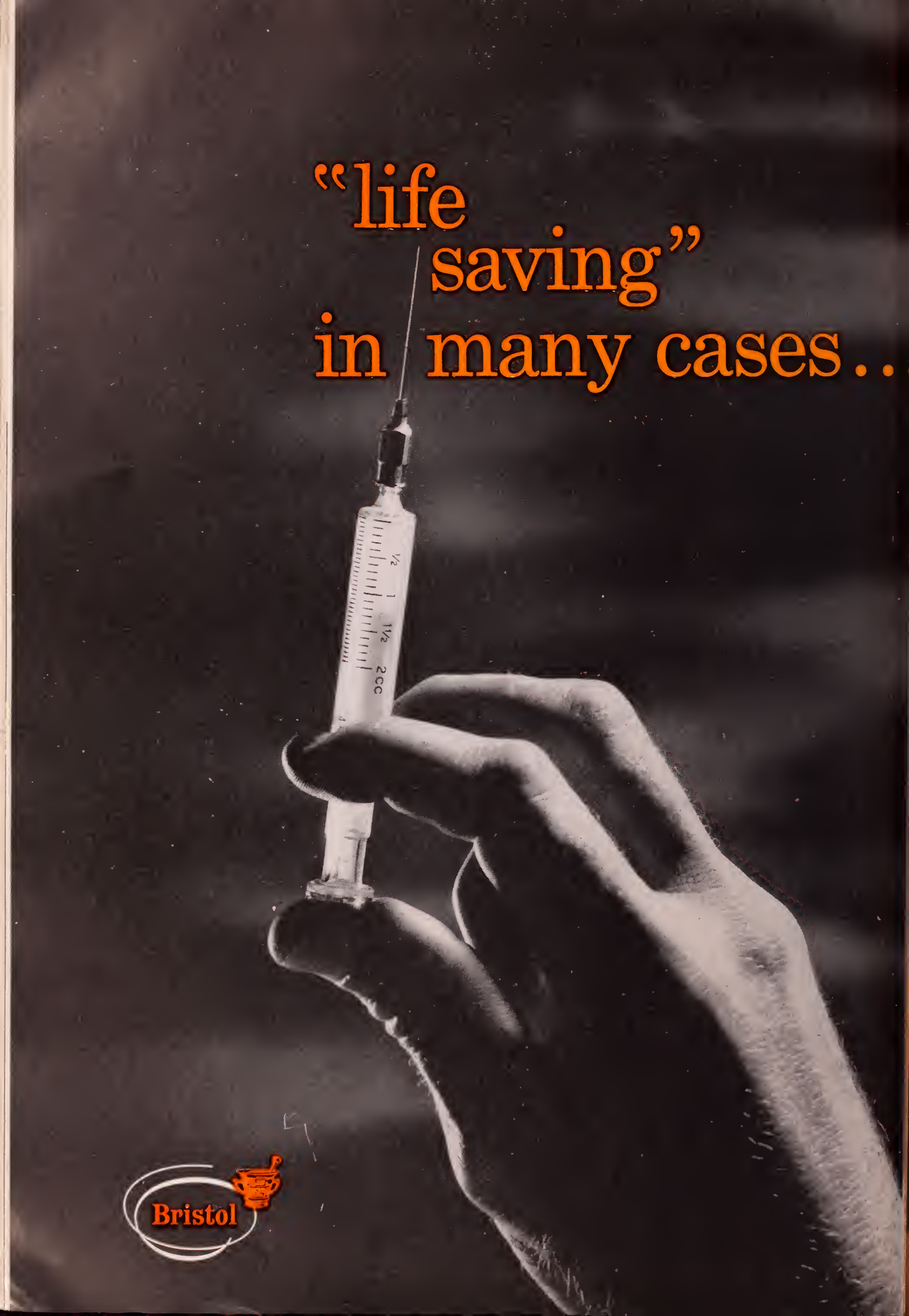
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REFERENCES: 1. Yow, E. M.: Practitioner 182:759, 1959. 2. Yow, M. D., and Womack, G. L.: Ann. N. Y. Acad. Sci. 76:363, 1958. 3. Bunn, P. A., Baltch, A., and Krajnyak, O.: Ibid. 76:109, 1958. 4. Council on Drugs, J.A.M.A. 172:699, 1960.

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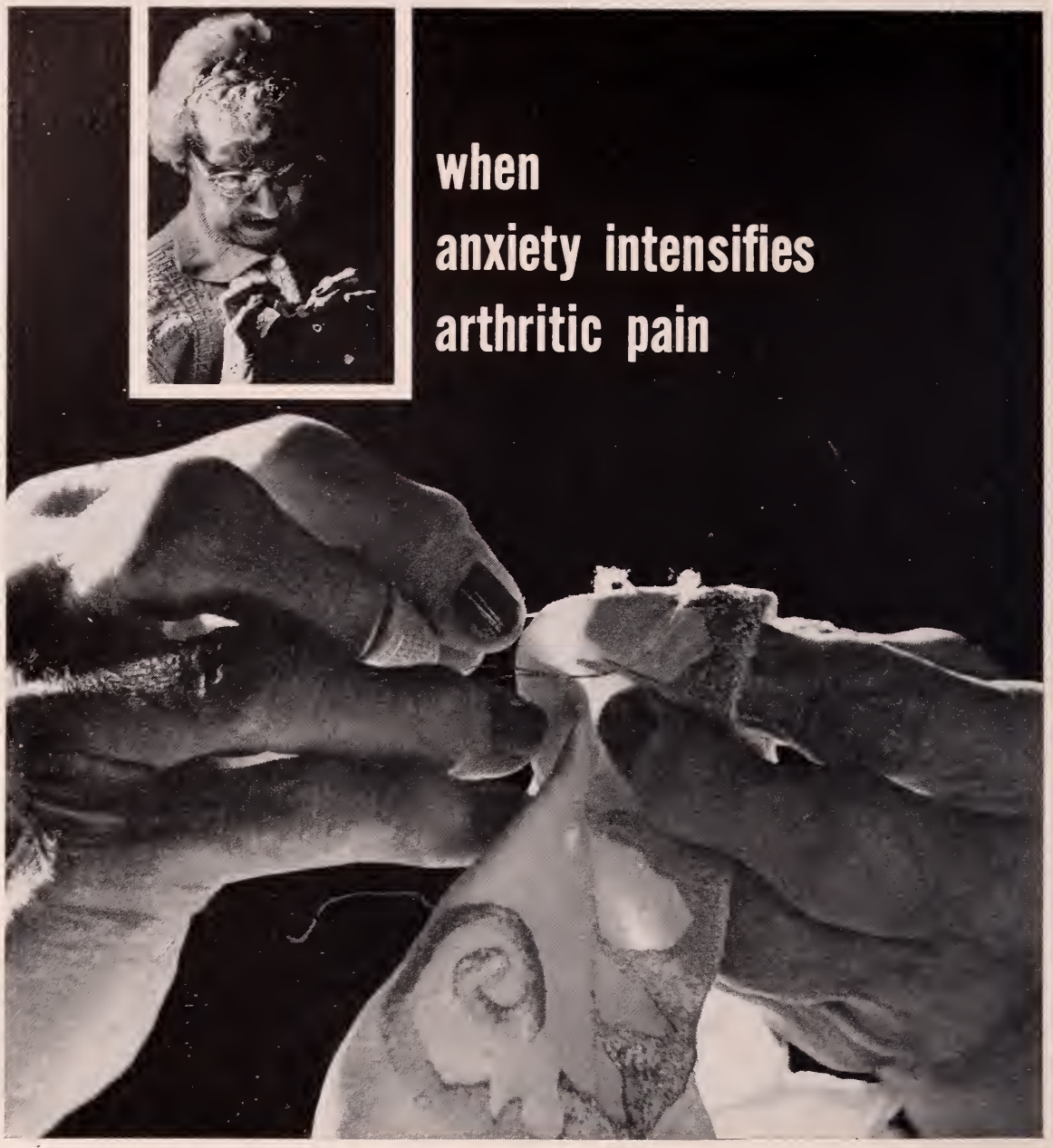

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THE JOURNAL
OF THE
FLORIDA MEDICAL ASSOCIATION

Volume XLVI, No. 12, June, 1960

Presidential Address

RALPH W. JACK, M.D.
MIAMI

When your various county societies ratified the new Charter and By-Laws for our Association this year, nobody suggested a change regarding the duties of the President. The By-Laws still clearly state that he "shall deliver an address at the annual meeting of the House of Delegates." They definitely state that it shall be an address and say nothing about giving a report. I will not, therefore, belabor you with a repeat of the reports of your Board of Governors and your Committees so ably presented in the Handbook for Delegates and in the supplemental reports still to follow here by the chairmen of your various Committees. The Delegates, I am sure, have already read these reports, and the seated alternates will do so at their earliest opportunity. You are or will therefore be better acquainted with the efforts and accomplishments of our Association during the past year than you would be by any briefing I could now give you. Instead of such repetition I shall use these few moments with which I am endowed by virtue of my office to give you a brief summary of my personal feelings about the role of organized medicine in our individual communities and in the world of today.

Before appearing to pass over the work of your various Committees and Boards so lightly, however, I do wish to say a few words about them. It has been my privilege to be a member of this House since 1946 when I returned to private practice from military duty. I have served on several of your Committees and as chairman of some. I am an eye witness to the many hours of hard work and unselfish effort expended for your benefit and for the benefit of the public we serve by your committeemen and board members. Those of this past year have been no exception. I wish there were time to mention by name and tell you of the many personal sacrifices I have seen made to accomplish something for our benefit and I know that there were many more that did not come to my individual attention.

Dr. Jack

The success of any presidential administration rests largely upon the work and cooperation of the other officers and supporting members. On behalf of the Association I wish to thank and

Read before the Florida Medical Association, Eighty-Sixth Annual Meeting, Jacksonville, April 8, 1960.

also to express my personal appreciation to the other officers for this past year, to the Board of Governors, and to the chairmen and members of all of the Committees for their unselfish service. On behalf of the officers and official representatives, I wish to thank the entire membership for its very fine cooperation. On behalf of all of us, I wish to give particular credit where credit is so greatly due—to all of the personnel in the Executive Office.

If any of you have never visited the Executive Offices of our Association, do not miss the opportunity of doing so while you are in Jacksonville. I know you will be proud of what you find there and I believe you will be amazed to learn all of what goes on there. Doctors, the business of the Florida Medical Association has become "Big Business." It certainly is most important business for you and me. I could spend the rest of the day here talking about the constant changes in Medical Science, the change in social and political philosophies and their effect upon our everyday life. Those looking after your affairs on a state level have all of these constant changes to keep up with. Mr. W. Harold Parham and the staff he has organized for us have been doing exceptionally well and have your interest very much at heart. Stand ready to give them whatever added support they need. They will need additional support as time marches on, but they will not ask for it until necessary. It is in your interest that they obtain the additional support needed when they request it.

For the past three years you have bestowed repeated honors upon me. Three years ago you made me your First Vice President. Two years ago, you made me your President-Elect. Last year you bestowed upon me your greatest honor by inaugurating me as your President. I hope that our Association has benefited in some small degree by my being in such positions. The experiences of such offices have immeasurably enriched my life. I extend to you my appreciation for the privilege of thus representing you as well as my apologies for any inadequacies or failures.

I stated earlier that I wished to tell you my personal interpretation of the role of organized medicine in this ever changing world of today. We must never let up on our prime responsibility —that of treating the sick and injured. We now, however, not only have to treat the usual maladies of the individual, but we are faced with the problem of a nation of people weakened by a functional type of condition we call "apathy," now being attacked by a malignant parasitic disease we call "socialism." When I use that latter word, I feel a little like the doctor who politely referred to lues to avoid the social stigma of saying syphilis. We have the job of curing our public of this combined symbiotic illness. We must do it because if we do not, there will be nobody to do it.

During the past few years, as I have been attempting to do my job for our Association, I have had many ask me—"Why?"—"Why bother?"—or—"What is the use?" And still others will say—"It's already too late"—or—"The handwriting is already on the wall." Whenever I hear such remarks, they bring to mind a little poem I have known since boyhood and which I believe is still worth reciting:

If you think you're beaten, you are,
  If you think you dare not, you don't,
If you'd like to win, but think you can't,
  It's almost a cinch you won't.
If you think you'll lose, you're lost,
  For out in the world we find
Success begins with a fellow's will,
  It's all in the state of mind.

Full many a race is lost
  Ere ever a step is run,
And many a coward fails
  Ere even his work's begun.
Think BIG and your deeds will grow,
  Think small and you'll fall behind,
Think you can and you will,
  It's all in the state of mind.

If you think you're outclassed, you are;
  You've got to think high to rise,
You've got to be sure of yourself before
  You can ever win a prize.
Life's battles don't always go
  To the stronger or faster man,
But sooner or later the man who wins
Is the fellow who thinks he can.

I acceded to your Presidency during the 150th year of Lincoln. I feel it altogether fitting that at this time we should remind ourselves of the closing words of his memorable oration at Gettysburg in November 1863, just ten years before the birth of this Association here in Jacksonville in November 1873. To quote, "It is rather for us to be here dedicated to the great task remaining before us; . . . that this nation, under God, shall have a new birth of freedom, and that government of the people, by the people, for the people shall not perish from the earth."

To carry out our part of accomplishing such a task we must cure our people of their common public diseases. To do so, we must not only be good physicians, but we must also be true phy-

sicians in every sense of the word and in addition we must become expert teachers. In the latter capacity we must be teachers of history and of reality. It is up to us constantly to remind our people of what really made this Nation great, of the true facts in our history that made us a leader among nations. We must remind them of the hard work, long hours, ambitions, disappointments and heartaches of our ancestors on this continent. Forty hour weeks did not build this Nation. It was founded on the concept of freedom but not freedom from responsibility. It took a lot of work to build a democracy and it will require a lot of work to keep it going. The Lord worked for six days and then rested on the seventh. He did not start out resting.

We must also teach about the reality of values of tomorrow. When I studied chemistry, we learned that gold was a fundamental element. It does not reproduce itself. You cannot put a small piece in the pot today and draw out handfuls tomorrow.

As true physicians we must be concerned only with the welfare of our patient, which at this time is our national community. We have no time to be concerned about ourselves either individually or as a group, or should I say—profession? Let us stop worrying so much about "socialized medicine" or "government control of medicine" or the like. Let us pay great heed to and emphasize to our public what is happening to "US"—the people of the United States as a whole. There is no time now for considerations of selfish motives of any group. Let us as true physicians be unselfish as we have been trained to be and desist from talking about what is happening to "Medicine," but rather point out to our public what is tending to happen to American freedom before it is too late.

There are people in this world who have been sealed off from knowledge of the things we prize—human freedom, the rule of law, free speech, free press, free association, and freedom of worship. Generations have had drummed into them the need for hard work and achievement at the cost of much sacrifice and discomfort. They have been taught to believe that by accepting state direction and control, by unrelenting hard work, they can telescope their development from a primitive backward country to surpass the western world, particularly the United States, within a few decades. We have seen enough in the past few years to realize that this achievement is not so fantastic as it might have once seemed. From all reports these people are working long hours—in the schools—in the laboratories—and in the factories—and working harder, even if less efficiently, than we are.

We in America have maintained and still profess to believe that individual initiative in our economic life, free competition, and all that is summed up in the phrase—"Free Enterprise"—have produced in the past and will produce in the future a greater abundance of goods and services for all of the people. We believe it will also give us a stronger, more flexible, more dynamic and more progressive economy. So far, beyond all doubt this has been so.

This system depends upon the individual or the private business facing its own problems, meeting the challenge of opportunity or difficulty, facing the hazards of success or failure. I have to wonder, however, if this does not become less true every day. Are we letting the Democratic way become more and more the easy way? It seems that the solution to every problem, every risk, every difficulty, is sought in some new form of protection from the facts of life. A new law, a new handout, a new government regulation. Our schools seems to have concentrated on adjustment rather than achievement. Do our workers really want seniority to replace merit? Security to replace opportunity? More pay for less production?

Today it seems most young people applying for work want to know:—"What are the hours?" —"How much vacation?"—"Your pension plan?" —"Security?"—*Not*—"What are the opportunities?" In almost every part of our life we seem to seek protection from work, from difficulty, from the challenges that our pioneer fathers gloried in. Whenever professional and business men gather, we shake our heads about government intervention in business or what we believe should be our private affairs. Then when faced with some slight difficulty, so many run to the government for protection, thus placing themselves more and more in government hands. This seems to be the trend today. Such actions, of course, hurt us immeasurably. Each time we scuttle behind the skirts of government for assistance or for protection from problems we should cope with as private individuals or groups, we depart from the principles we profess. We weaken the free response to opportunity, to challenge and to difficulty that made this Nation so great.

Standards of medical practice and achievement on this continent are the highest in the world. They will remain so in my opinion only so long as Medicine remains free of government and solves its own problems by its own dynamic individual and collective response to the challenges presented to it. Doctors, again in my opinion—it is up to us.

100 West San Marino Drive, Miami Beach.

No One Without Adequate Medical Care

LOUIS M. ORR, M.D.
PRESIDENT OF THE AMERICAN MEDICAL ASSOCIATION
ORLANDO

As many of you may know, last month I demanded an apology and a retraction from the AFL-CIO for untrue and scurrilous charges made against the American Medical Association, its 178,000 members and its state and county medical societies. In a lengthy document sent to Mr. George Meany, the A.M.A. took up each of the 15 allegations of the AFL-CIO's political education arm, COPE. Each allegation was refuted and shown to be false.

I received a reply from Mr. Meany a few weeks later. After three or four paragraphs of introduction, Mr. Meany said in his letter: "The record recited by the COPE article was the record of the A.M.A. in the political and economic fields. We have re-examined this record and find no basis for retraction. In fact, most of the record can be documented by statements which appeared in official publications of the American Medical Association." That was Mr. Meany's answer. In my first letter to Mr. Meany I included our refutations—carefully documented—to all 15 COPE allegations. In his reply Mr. Meany provided us with no documentation whatsoever.

In addition, Mr. Meany answered me to the effect that the COPE charges against the A.M.A. dealt with the A.M.A. record in political and economic fields. He implied that COPE's attack was based upon A.M.A. actions in areas "outside" its field of competence. I have answered Mr. Meany. I have stated that the allegations by COPE did specifically involve health and medical matters—tuberculosis, smallpox vaccination, diphtheria and contagious diseases, infant and maternal deaths, venereal disease clinics, TB and cancer centers, blood banks, school health, public health units, health insurance, medical education and Medicare.

Dr. Orr

After extracting all the wind out of Mr. Meany's reply, I can only conclude that I was correct in demanding an apology and a retraction for the distortions of the truth made by COPE. I stand on this document of our refutations of the scurrilous charges. I have told Mr. Meany so in a second letter to him last week. I have said to him that his answer to me begs the main issue: Were COPE's charges true or false? I hope that we can have a second answer from Mr. Meany—an answer that responds to our question and not one that evades the issue.

Read before the Florida Medical Association, Eighty-Sixth Annual Meeting, Jacksonville, April 11, 1960.

While I am on the subject of setting the A.M.A. record straight for those critics who do not take the time or make the effort to seek the facts and the truth, let me tell you about the real A.M.A. Let me answer the often heard charge that the A.M.A. opposes everything. Let us look at the facts; let us look at the record.

In the first session of the 86th Congress 512 bills—all in some way relating to medicine and health—were introduced. Obviously, all of them could not be considered or acted upon. In fact, only a small percentage were considered. Of the 19 on which the A.M.A. presented testimony, the A.M.A. favored 14 measures. The A.M.A. provided information only on four bills and opposed just one proposed measure. The record then is 14 for, 4 informational only, and 1 against. But to listen to our critics you get the impression that the A.M.A. has a medieval approach to health issues and legislative measures.

Let me also remind you that the one bill we opposed was the Forand bill—a measure which was voted down 15 to 8 in the House Ways and Means Committee . . . a bill which President Eisenhower has opposed firmly . . . and a program which we believe could be the beginning of the end to voluntary health insurance and the private practice of medicine. Indeed, it could be the beginning of the end to all things voluntary and private. We are not so naive as to think that a committee vote and a President's opposition are all that is needed to halt Forand-type legislation this year or in years to come. The vote in the House Ways and Means Committee is by no means the final word on Forand-type legislation. The bill must be fought today, tomorrow and in years to come.

The forces behind such legislation are strong and exceedingly vocal. Allow me to show you just how strong and vocal by giving you some excerpts from a report on the UAW's recent rally in Detroit to get signers on Forand bill petitions:

"Five Democratic politicians (Senators Humphrey, Kennedy, Symington and McNamara and Rep. Machrowicz) and Walter Reuther entertained 10,000 cheering old people by promising them the Forand bill, by campaigning for a Democratic president in November and by roasting the American Medical Association. . . .

"A brass band, the Senior Citizens Square Dance Club and an impressive speakers platform lent the rally an emotional, revival-meeting spirit that the politicians found delightful. . . .

"The A.M.A. was lumped together with President Eisenhower, Old Guard Republicans, the NAM, the 'heartless' administration and other 'coldhearted, selfish pressure groups'. . . .

" 'If we follow the advice of the A.M.A., then each senior citizen will become a bum.' McNamara yelled. . . .

" 'You're going to get medical care through Social Security,' Reuther promised. . . ."

Just last week another labor leader, James Carey, vilified the American physician with this statement: "What the American Medical Association, the insurance firms, the administration and others want is discrimination against all of our elder citizens—to deny them the right to the humane and decent medical care they need and which our society can so readily afford." The Chicago Sun-Times commented editorially by saying that Mr. Carey had "spoken like a demagogue." "The charge could more accurately have been aimed at Carey," the editorial continued, "and the others who profess to find in the Forand bill the ideal solution to the problem of protecting elderly people from the financial catastrophe of long and costly hospital and surgical care."

Only two weeks before Mr. Carey's outburst, the Wall Street Journal also had commented editorially on the subject of the aged, medical care and society's responsibilities. Excellently written, the editorial concludes:

"The good society will always grope for better ways to take care of those who cannot take care of themselves.

"But the wise society will not confuse intentions with intelligence. It will not so order itself with vast and costly programs that in trying to relieve the hardships of the few it does injury to the efforts of the many to prepare against them.

"To do that, to heap heavier burdens upon all the citizens in the name of freeing them from burdens, is not humane. And, as the world around us shows, making all the people the wards of the State is not the wise way to the good society."

Many of those supporting Forand-type legislation have been working in the Social Security system since its inception. Not content with a cash-benefit Social Security program, these same persons now wish to add service benefits. The idea is a little medical care for some in the begin-

ning, and then full federal control of medical care and hospitalization for all in the long run.

Despite the gloom-and-doom reports of the proponents of federal medical care that most of the aged population is disabled by illness or verging on bankruptcy—or both—the truth is that most older persons are healthier than often represented to be. And, they are much better off financially than proponents of Forand-type legislation will admit. Certainly, I am not suggesting that the aged are healthier than they were at the age of 35, nor am I saying that all old people play the stock market, vacation in Europe and go North for the summer. What I am saying is that few are disabled and few are without monetary funds. There are some who are disabled and there are some without finances.

But I say that the physicians of Florida and the physicians of this country are determined to see that all persons get the best medical care available, regardless of their ability to pay for it. Indeed, medical care is available to every man, woman and child in the United States regardless of his or her ability today. That care is not now denied, nor will it be denied. Some may not know about this service of the medical profession, or some may be too proud to ask for it, but the offer exists, nevertheless.

Furthermore, and I emphasize this to you this afternoon, no one—including all the proponents of federal medical care for the aged via Forand-type legislation—has shown that elderly persons who cannot pay for their own medical care are not getting it now. Attempts have been made to show that in rare instances a person is not receiving such care. But when these rare cases are investigated, it usually has been shown that the individual prefers to provide the medical service and care himself or that he has never made a sincere effort to obtain the necessary medical and health services.

I believe that by concentrating on the small minority of our aged who represent an extreme situation—medically, emotionally, socially and economically—the proponents of Forand-type legislation are drawing a distorted picture for the American public. They have magnified the problems of a minority segment to such an extent that their image of the total group has become blurred. They deduce, as a consequence, that most of our 15½ million older Americans are in poor health . . . are living on reduced incomes . . . are less able to contribute to their family or community . . . are no longer as capable of producing . . . and are living on the verge of an acute financial emergency.

Yet, despite individual cases of hardship, the elderly today have better medical treatment and better care than ever before in history, and more important, better treatment and better care than they do in countries with government-controlled and government-run medicine.

The prime concern of the medical profession is, and always has been, to serve humanity regardless of reward or financial gain. Every physician in this room has given hundreds of dollars worth of medical treatment and care to the needy on a no-pay basis, or on a reduced-fee basis. This has been going on since time immemorial and there is no reason to believe that it will not continue in the future. Our greatest concern, even now as we face the threat of Forand-type legislation, is the best possible quality of health care for all the people—the elderly emphatically included.

1300 Kuhl Avenue.

Proceedings
Eighty-Sixth Annual Meeting

Florida Medical Association
Jacksonville, April 8-11, 1960

General Session

The eighty-sixth annual meeting of the Florida Medical Association was called to order at 1:55 p.m. Saturday, April 9, 1960 in the Windsor Room North, Hotel Robert Meyer, Jacksonville, by President Ralph W. Jack.

Dr. Jack called upon Dr. Albert Kissling of Riverside Presbyterian Church, Jacksonville, to pronounce the invocation.

"Almighty God, our Heavenly Father, Creator of all life, Author of all good, Father of all spirits, we give unto Thee most hearty thanks for the glory of life today in the world beautiful. We give unto Thee most hearty thanks for the energy and desire of the heart and mind of man to push back the shadows of ignorance. We give Thee thanks for these, Thy servants, co-workers in the bringing of health to body and mind. Grant Thy divine favor upon them, as they fulfil Thy holy will in the healing of body, in the blessing of mind, and in their deliberations, Gracious God, hold before them new vistas down which they may move for the blessing of Thy people. And so, Gracious God, in the name of the Great Physician, even our Lord Jesus Christ, we give Thee thanks and invoke Thy presence for blessing. Amen."

Dr. Jack: "I will now ask Dr. Floyd K. Hurt, President of the Duval County Medical Society here in Jacksonville, to give us a word of welcome."

Dr. Hurt: "President Jack, Members of the Florida Medical Association, Members of the Auxiliary and Distinguished Guests, we are truly glad that you are back with us again this year for the annual meeting of the FMA. It has been 12 years since we have had a meeting of this type here, the last meeting was in 1946, but interestingly enough during the past week in the Florida Times-Union there was a short news item which I thought might be of interest to you now. It comes under the heading of '50 Years Ago Today.' 'On April 6, 1910 the 37th annual convention of the Florida Medical Association opened today for a three day meeting,' so history has a tendency to repeat itself.

"We realize that you are here under a sort of accelerated program this year and time is short and we do want you to spend as much time as possible with the scientific and technical exhibits and in the scientific sessions but there are some interesting things in and about Jacksonville which you might have time for and wish to visit. Mr. George Tobi of our Tourist and Convention Bureau has told me that the girls who are at the registration desks will be glad to help you arrange a trip to any spot that you might like to visit.

"Again, we are delighted that you are here and hope that it won't be 12 years before you are back with us again. Thank you."

Dr. Jack: "Dr. Lee Howard, our fraternal delegate from Georgia, has now arrived in Jacksonville and I take pleasure in introducing Dr. Howard to you. He is the immediate past president of the Medical Association of Georgia. Do you have any message from Georgia, sir?"

Dr. Howard: "Mr. Chairman, members and guests, I first want to bring you warm greetings and felicitations from the Medical Association of Georgia. Incidentally, your president-elect is a Savannahian and a life-long friend of mine and I want to extend my congratulations to him. About a year ago we purchased a building for our headquarters, and were able to pay almost two-thirds of the cost outright and have enough over to furnish the building nicely. In addition to the offices of the president and executive office personnel the building includes offices for Medicare and an auditorium seating around 100 people. I

thought it might be interesting for you to know what we are doing in the way of owning a building. For several years we have had a building fund and two years ago we raised our dues from $15 to $25 and thus we will soon be able to finish purchasing our new headquarters building.

"Over the past several years we have had very pleasant and fruitful liaison with your Association. It certainly has been helpful to us and I hope that it has been mutually so. We have recently gone into an insurance plan with the Life Insurance of Georgia, which has received a surprising response. It covers everything; health, accident, life and liability. Out of 2,400 or 2,500 practicing physicians who are members of MAG, about 2,300 have already signed up for it.

"I have certainly enjoyed being here and I think Jacksonville is an excellent location and you are having one of your biggest and best meetings here this year."

Dr. Jack: "Thank you, Dr. Howard. The Florida Medical Association sends its warmest wishes back to Georgia by you and we urge all of you to come down to Miami for the AMA meeting in June."

Dr. Jack: "Dr. William A. Soderman, Dean of Jefferson Medical College of Philadelphia, is with us today and I am happy to introduce him to you.

"I know some of you will be disappointed that Senator George Smathers is unable to be with us this afternoon as he has been held up in Washington due to the civil rights bill but he will be at the reception at the Mayflower Hotel this evening and you will have an opportunity to see him at that time.

"I am also disappointed that the Senator isn't here for an entirely different reason. I had planned to have a Democratic Senator introduce my Republican Congressman Guest Speaker to you, so I am left with that job myself. But I do want you all to know my first acquaintanceship with Congressman Curtis was last October when I attended, as one of your representatives, a special AMA conference in St. Louis. If there has been some good that I have done for you during the course of this year, there is no question in my mind but that some of it was stimulated by Congressman Curtis. He sort of lit a fire under me when I was in St. Louis and I hope, I anticipate, and I believe he will do the same to you today. I definitely regard the Congressman as one of the best friends medicine has in Washington but more than that, I think he is one of the best friends that Americans have in Washington. He is now in his tenth year in the House of Representatives and in his fifth term in Congress. There have been a few people like Walter Reuther and friends of his who haven't been very anxious for Tom Curtis to go back to Congress, but thank goodness there are enough Missourians, at least in one district, who don't agree with those gentlemen. The Congressman is the ranking minority member of the Joint Economic Committee in Congress and he is also the ranking minority member of the Social Security Subcommittee of the House Ways and Means Committee. He was one of the leading fighters on the House Ways and Means Committee during the recent hearings, discussions and action on the famous Forand Bill, H.R. 4700. Now this is enough to hear from me. It is my special privilege here today to bring to you the Honorable Thomas B. Curtis of Missouri."

(Congressman Curtis' speech will be published in the July issue of The Journal.) Dr. Jack: "Congressman Curtis, it is obvious, I think, how much we appreciate your being with us today and I want to thank you for making this trip and appearing before us.

"We will now have a 10 minute recess before the Second Scientific Session."

The General Session adjourned at 3:25 p.m.

First House of Delegates

The House of Delegates convened at 2:00 p.m. on Friday, April 8, 1960, in the Windsor Room North, Hotel Robert Meyer, Jacksonville, Florida, with President Ralph W. Jack in the chair.

The invocation was pronounced by Dr. Homer L. Pearson Jr., of Miami: "Our Gracious Heavenly Father, we thank Thee for this day. We thank Thee for our lives, for our ability to think, act, and work for Thee. We pray that Thou wilt be with us during this meeting. Grant us the strength, wisdom, understanding, tolerance and love to make the decisions necessary to carry on our great work. Help us to be ever mindful that we are only instruments in Thy hands and that without Thee we are nothing. Bless the officers and members of this Association. Guide us in our work from day to day we ask in Thy name. Amen."

Dr. Jack: "The Chair wishes at this time to recognize the Parliamentarian, Dr. George F. Schmitt Jr. of Miami."

Dr. Jack: "I wish also at this time to take special recognition of my helpers throughout this year. I would like to introduce to you Dr. Leo M. Wachtel, our President-Elect; our First Vice President, Dr. Eugene B. Maxwell; our long-term Secretary-Treasurer, Dr. Samuel M. Day; and our Executive Director, W. Harold Parham.

"I wish at this time to announce the membership of the Credentials Committee, Dr. Franklin J. Evans, Chairman, and Dr. Egbert V. Anderson of Pensacola. Unfortunately Dr. Rowland E. Wood of St. Petersburg had illness in the family and was not able to be here. I would like to call on Dr. Evans for a report of the Credentials Committee."

Dr. Evans: "Mr. President, I am pleased to report that out of a total number of 208 delegates we have a registration of 177 which is more than enough to make a quorum of the House."

Dr. Ralph W. Herz of Monroe moved that the House be seated.

The motion was duly seconded and carried.

Delegates

ALACHUA—Henry J. Babers Jr., F. Emory Bell, Eugene H. Cummings, Walter E. Murphree

BAY—William C. Roberts *(Absent—Sidney E. Daffin)*

BREVARD—James R. Doty, Theodore J. Kaminski, Thomas C. Kenaston, Arthur C. Tedford

BROWARD—Miles J. Bielek, Alexander H. Bluestone, Fred E. Brammer, Russell B. Carson, Anthony C. Galluccio, Donald H. Gahagen, Walter J. Glenn Jr., Russell R. Hippensteel, Robert J. Patterson, Leigh F. Robinson, Randall W. Snow, W. Dotson Wells, Scottie J. Wilson

CHARLOTTE—*(Absent—Carl N. Reilly)*

COLLIER—*(Absent—Daniel B. Langley)*

COLUMBIA—Laurie J. Arnold Jr.

DADE—James L. Anderson, Edward R. Annis, Jack Q. Cleveland, Vincent P. Corso, Edward W. Cullipher, DeWitt C. Daughtry, Robert F. Dickey, L. Washington Dowlen, Franklin J. Evans, Willard L. Fitzgerald, M. Eugene Flipse, Thomas S. Gowin, Harold O. Hallstrand, W. Tracy Haverfield, R. Spencer Howell, James J. Hutson, Paul S. Jarrett, Walter C. Jones, Christian Keedy, Robert P. Keiser, Donald F. Marion, John D. Milton, Warren W. Quillian, Hunter B. Rogers, Walter W. Sackett Jr., Ralph S. Sappenfield, George F. Schmitt Jr., Clifford C. Snyder, Franz H. Stewart, Joseph S. Stewart, Collins W. Swords Jr. *(Absent—Julius Alexander, Morris H. Blau, John E. Burch, Turner E. Cato, Richard C. Clay, Francis N. Cooke, H. Clinton Davis, Raymond L. Evans, Richard M. Fleming, Milton S. Goldman, Maurice M. Greenfield, Morton M. Halpern, John V. Handwerker Jr., Thomas W. Hutson Jr., David Kirsh, Donald W. Smith, Nelson Zivitz)*

DESOTO-HARDEE-GLADES—Gordon H. McSwain

DUVAL—Sullivan G. Bedell, James L. Borland, Frederick H. Bowen, Robert J. Brown, Hugh A. Carithers, J. K. David Jr., Emmet F. Ferguson Jr., Floyd K. Hurt, Gordon H. Ira, Edward Jelks, Joseph J. Lowenthal, Charles F. McCrory, Kenneth A. Morris, A. Sherrod Morrow, John T. Stage, Sidney Stillman, G. Dekle Taylor, Ashbel C. Williams

ESCAMBIA—Egbert V. Anderson, Herbert L. Bryans, Luther C. Fisher Jr., Sidney G. Kennedy Jr., George W. Morse, Walter C. Payne Sr.

FRANKLIN-GULF—John W. Hendrix

HIGHLANDS—Donald C. Hartwell

HILLSBOROUGH—Samuel H. Adams, Ernest R. Bourkard, C. Frank Chunn, Herschel G. Cole, H. Phillip Hampton, Samuel G. Hibbs, Herbert B. Lott, David R. Murphey Jr., James N. Patterson, William R. Rowlett, Wesley W. Wilson *(Absent—Linus W. Hewit)*

INDIAN RIVER—Erasmus B. Hardee

JACKSON-CALHOUN—James T. Cook Jr.

LAKE—Frederick C. Andrews, C. McK. Tyre

LEE-HENDRY—H. Quillian Jones *(Absent—Fred D. Bartleson)*

LEON-GADSDEN-LIBERTY-WAKULLA-JEFFERSON—T. Bert Fletcher Jr., Nelson H. Kraeft, Robert H. Mickler, George S. Palmer

MADISON—Thomas G. Bouland Jr.

MANATEE—Irving E. Hall Jr., Richard V. Meaney

MARION—William H. Anderson Jr., Eugene G. Peek Jr.

MONROE—Ralph Herz

NASSAU—B. Joe Wilder

ORANGE—Louis P. Brady, Norman F. Coulter, Harry H. Ferran, Truett H. Frazier, Harold W. Johnston, Carl S. McLemore, Fred Mathers, Louis C. Murray, Charles R. Sias, W. Dean Steward, Miles W. Thomley, Robert L. Tolle, Robert E. Zellner

PALM BEACH—Willard F. Ande, James F. Cooney, C. Jennings Derrick, V. Marklin Johnson, Walter R. Newbern, S. Richard Ombres, Ralph M. Overstreet Jr., Cecil M. Peek, William H. Proctor, Younger A. Staton

PASCO-HERNANDO-CITRUS—S. Carnes Harvard

PINELLAS—Clyde O. Anderson, Elmer B. Campbell Sr., Chas L. Farrington, Earl R. Fox, N. Worth Gable, Francis H. Langley, Norval M. Marr Sr., John P. Rowell, George H. Schoetker, Walter H. Winchester, *(Absent—Edward L. Cole Jr., John P. Ferrell, Jack A. MaCris, J. Braden Quicksall, Robert T. Walker, Rowland E. Wood)*
POLK—Clarence L. Anderson, Samuel J. Clark, John E. Daughtrey, Newell J. Griffith, Marion W. Hester, Charles Larsen Jr. *(Absent—Arthur J. Moseley Jr.)*
PUTNAM—Fairfax E. Montague
ST. JOHNS—Herbert E. White
ST. LUCIE-OKEECHOBEE-MARTIN—John M. Gunsolus, Richard F. Sinnott
SARASOTA—John M. Butcher, Karl R. Rolls, Melvin M. Simmons, Millard B. White *(Absent—Samuel E. Kaplan)*
SEMINOLE—Vann Parker
SUWANNEE-HAMILTON-LAFAYETTE—Shirley L. Hadden
TAYLOR—Walter J. Baker
VOLUSIA—Thomas D. Cook, Peter A. Drohomer, Theodore F. Hahn Jr., Herbert D. Kerman, Achille A. Monaco, William W. Schildecker
WALTON-OKALOOSA-SANTA ROSA — Frederick F. Crews, Eric F. Geiger
WASHINGTON-HOLMES—*(Absent—Walter H. Shehee)*
STATE OFFICERS—Ralph W. Jack, Leo M. Wachtel, Eugene B. Maxwell, Henry L. Harrell, Jere W. Annis, Samuel M. Day
AMA DELEGATES—Reuben B. Chrisman Jr., Francis T. Holland, Burns A. Dobbins Jr., Meredith Mallory

Dr. Jack: "I wish at this moment to call on Dr. Thad Moseley for a couple of announcements he wishes to make. I think all of you know that Dr. Moseley is the chairman of the Scientific Work Committee which has helped to make this meeting possible."

Dr. Moseley: "As the representative of the Scientific Work Committee, I would like to ask each of you to enjoy yourselves fully at our meeting in Jacksonville and also to take advantage of the scientific sessions which have been prepared for you. We hope it will be an outstanding program. We have two things to call to your attention. The first is that there is an excellent program of scientific exhibits in the auditorium of the George Washington Hotel and I urge each of you to make an effort to visit these exhibits. Secondly, the scientific sessions that have been prepared are excellent and I would like to have you all attend, and to stimulate this attendance we have three transistor radios which will be drawn for door prizes. These will be given to those present at the start of each scientific session. They are not rewards for attendance, for we think the excellence of the program itself warrants your attendance, but they are rewards for promptness, and I hope that each of you will take advantage of the opportunity to win a radio by being prompt. Thank you."

Dr. Jack: "Thank you, Dr. Moseley. I would like to call your attention to a form in your delegate's packet regarding your trip insurance. You are, as official delegates to the Florida Medical Association, insured for $25,000 on your travel during this convention and the certificate is in your folder.

"At this time it becomes my special pleasure to introduce the representative from one of our sister professions in the state. He comes in keeping with a very fine tradition established between our two organizations a few years back. It was my very distinct pleasure to represent you at the meeting of The Florida Bar when it was held in Miami this past Spring. Right now I have the pleasure of introducing to you the President of The Florida Bar. J. Lewis Hall of Tallahassee became the President of The Florida Bar on May 23 at the close of the 1959 convention in Miami Beach. He succeeded Mr. O. B. McEwan of Orlando and, of course, you know this Association is well familiar with the McEwan clan. Mr. Hall has served continuously on the Board of Governors since 1954. A native of Leon County, he is a member of the Tallahassee firm of Hall, Hartwell and Douglass. He attended the University of Florida where he was a member of Florida Blue Key, editor-in-chief of the Alligator, and a member of Sigma Delta Chi, honorary journalistic fraternity. The president has served as attorney for Leon County since 1938, and in 1942 was president of the County Attorneys Association of the State of Florida. He is a member of the American Bar Association and served for four years as chairman of The Florida Bar's Legislative Committee. He was a member of the Fabisinski Committee, and was one of the attorneys designated by The Florida Bar to serve on the Florida Constitution Advisory Commission. Active in Masonry, Mr. Hall is immediate past Grand Master, the Most Worshipful Grand Lodge F. & A. M. of Florida. Mr. Hall."

Mr. Hall: "Thank you, President Jack, for that most generous introduction. I had hoped to talk for one minute but I certainly want to take as much time as you took in presenting me to this group. As I listened to that roll call of distinctions, if I may so dignify it, I was reminded of a story my circuit judge told me the other day. He had a rather dull-witted defendant who had just been convicted by the jury and was about to send him off to Raiford. The boy had asked for clemency and the judge reached down among his papers and pulled out the boy's record which they

had procured from the FBI and began to read it to him. He had been convicted in this place and that, in Iowa and Washington, had been arrested in Rhode Island—he got about half way through when the boy looked up at him and said, 'Judge, where did you find out all that stuff?' Dr. Jack, I didn't know anybody had compiled that much about me.

"Members of the House of Delegates, it is a real privilege to appear before you and express to you the appreciation from myself and in behalf of The Florida Bar for the honor and privilege of coming before you to extend greetings from The Florida Bar, the more than 7,000 lawyers of this state who constitute the membership of our organization, and to take pride and pleasure with you, because I know that as we take pride and pleasure in it so do you, in the progress that has been made in coming to a better understanding between the two great professions of law and medicine.

"In the integration rule under which The Florida Bar is organized and created, we are assigned three great objectives and three great responsibilities: service to the profession, service to the public and service in the administration of justice. I want to say to you that there is a growing consciousness in the minds of the legal profession of the growing importance that doctors play in one of these great objectives, the administration of justice. I am sure there is a growing understanding on the part of each of the professions of the duties and responsibilities that the other plays in the administration of justice, in aiding the courts and juries in arriving at just verdicts based upon truth. We, of course, welcome the opportunity to work with you in that field. I think also that all of us are conscious in this growing era of social consciousness that each of our professions must progress and must recognize a responsibility to the public. In bygone days a lawyer had discharged in full his responsibility to society if, when a client came to him, he was faithful to that client's interests and gave him service; that was our concept of our responsibility. You, as doctors, when a patient came to you and you were faithful to that patient and gave him of your best skill and knowledge, had discharged your responsibility. Today that is no longer sufficient. Each of us is looked to in our respective fields, not only for a rendering of service to our individual clients and patients, but to give leadership to society in evolving the concepts and bringing about the principles and establishing those principles under which society will progress in health and in its social structure as we lawyers will try to evolve the principles for that progress.

"Now in our service to our respective professions, I know that each of you recognize the responsibility of the professional man, recognize that the earmark of a professional is freedom and independence to use his best judgment and skill in the matters entrusted to him. I am sure that through voluntary efforts on the part of the medical profession it will fully discharge its responsibilities to society without the necessity for governmental regulation or regimentation, just as we lawyers as professional people recognize that we must also have freedom from regulation and regimentation. I am sure that in future this closer understanding between the lawyers and the doctors will give evidence of that fact in our progress. So I am happy to appear before you this afternoon and appreciate the opportunity of saying these words to you and to pledge to you on behalf of The Florida Bar our continued efforts for a better understanding to uphold the position of the professional man in our society. Thank you."

Dr. Jack: "At this time the Chair would like to recognize the presence of the Executive Director of The Florida Bar, Mr. Paul B. Comstock, of Tallahassee. Delegates, I explained to Mr. Hall that we would understand if he has to leave shortly and I have assured him we will forgive him if he runs out on us pretty soon.

"It is now my pleasure to introduce to you one of the fraternal delegates here at our meeting, Dr. Hugh E. Gray, President-Elect of the Medical Association of the State of Alabama. Dr. Gray. We are indeed happy to have you here, sir. The delegates from Georgia have not arrived as yet and we will introduce them later on in our program.

"Is Mrs. Wendell Newcomb, president of our Woman's Auxiliary, here? I need say no more. I asked Mrs. Newcomb this year to bring us a message from the Auxiliary. Working closely with them this year I found out what a job they rtally do. Mrs. Newcomb:"

Mrs. Newcomb:

"Dr. Jack and Members of the House of Delegates:

The honor of being asked to represent the Woman's Auxiliary by speaking before this body is accepted with

a great pride, for it is a sure sign that liaison between the two organizations is becoming stronger. I would like to point out some of the activities of the auxiliary this year in which we feel that we have assisted you.

Recruitment of nurses and other allied medical personnel is one of our major endeavors. In this field we sponsor over 150 Future Nurses' Clubs in the high schools of the state. Programs on nursing and other allied fields are brought to these young people in an effort to encourage their entering some medical career. We feel that our efforts have been successful, for it has been proven that a girl who has been a Future Nurse rarely drops out of nursing school after she has entered. In this same field we have given two loans to nursing students this year. The state auxiliary matches funds given by county auxiliaries up to $250.

At the request of the House of Delegates of last year we sponsored essay contests in the high schools. This did not meet with the success that we had hoped for. Many high schools and also county medical societies were not receptive to the idea, and so we had only three counties entered. The essays were judged on the state level by a doctor, a lawyer and a college dean, and the three winning essays have been sent to the national headquarters for judging. The essays entered were excellent.

We have contributed, through our own efforts, approximately two thousand dollars to the American Medical Education Foundation this year. Programs have been given around the state on civil defense, safety and mental health.

Because of the great stress on legislation this year the auxiliary has made a concerted effort in this field. Almost every auxiliary had a program on legislation, with panels and speakers on the pitfalls of the Forand Bill being in the majority. We have written congressmen, and we have talked to our friends, individually and in groups. In each county I visited I spoke on the Forand Bill.

The auxiliary also sponsors Doctor's Day, which we consider our "fun day." Who can measure the public relations brought about by the mingling of all doctors and their wives in a county in a gathering such as this?

We are pleased to announce the organization of two new auxiliaries; one in Highlands County and one in Walton, Okaloosa and Santa Rosa Counties.

We stand ready to serve you. We want to be medicine's greatest ally."

Dr. Jack: "Thank you, Mrs. Newcomb. We thank you so much not only for these words but for all you have done all year, and it is also my privilege now to recognize Mrs. John M. Butcher, President-Elect of the Auxiliary. Mrs. Butcher, will you rise?

"The Chair will now entertain a motion for approval of the minutes of the 1959 annual meeting as they were published in the July 1959 Journal."

Upon motion by Dr. David R. Murphey Jr., seconded by Dr. Carl S. McLemore, and carried, the minutes were approved.

Dr. Eugene B. Maxwell, Vice President, took the Chair.

Dr. Maxwell: "A year ago you gave me the honor of selecting me Vice President of this Association. After I recovered from the shock of the thing, I suddenly realized that I would have the privilege of introducing and presenting a very old and dear friend and a former neighbor to give his presidential address, Dr. Ralph Jack."

(The complete text of the presidential address appears on page 1485)

Dr. Maxwell: "I am sure I express the thoughts of all of us here when I say that the message Dr. Jack has given us is one that we can take home and think about, and I want to thank him for this great message he has given us and also to thank him for a job well done as our president."

Dr. Jack: "Our next order of business will be the report of the Florida State Board of Medical Examiners, presented by Dr. Homer L. Pearson Jr., Secretary, which will be read by Dr. Morris B. Seltzer."

(Dr. Seltzer read the Report, which was referred to Reference Committee No. 4)

Dr. Jack: "Thank you, Dr. Seltzer. At this time I wish to announce the personnel of our reference committees. I would like to ask the chairman of the Credentials Committee to check me on these if all these men are not present."

Dr. Jack read the list of reference committee personnel.

1. HEALTH AND EDUCATION
   English Room
   Robert L. Tolle, Chairman
   Sidney Stillman
   John M. Butcher
   Miles J. Bielek
   Hunter B. Rogers
2. PUBLIC POLICY
   French Room
   Edward R. Annis, Chairman
   Henry J. Babers Jr.
   Clyde O. Anderson
   W. Dean Steward
   Eugene G. Peek Jr.
3. FINANCE AND ADMINISTRATION
   Executive Suite
   Edward Jelks, Chairman
   T. Bert Fletcher Jr.
   C. Frank Chunn
   Thomas C. Kenaston
   Nelson Zivitz
4. LEGISLATION AND MISCELLANEOUS
   Spanish Room
   Edward W. Cullipher, Chairman
   Walter E. Murphree
   Marion W. Hester
   Ralph M. Overstreet Jr.
   Robert F. Dickey

The following committee reports and resolutions were referred as published in the Handbook, together with supplemental reports and additional resolutions as presented in the delegates' packets:

(To Reference Committee No. 1)

Scientific Work, Thad Moseley
Medical Postgraduate Course, Donald F. Marion

Venereal Disease Control, C. W. Shackelford
Maternal Welfare, J. M. Ingram Jr.
Child Health, Warren W. Quillian
Liaison to State Board of Health, James T. Cook Jr.
*Tuberculosis and Public Health, M. Eugene Flipse
Cancer Control, George W. Morse

(To Reference Committee No. 2)

Conservation of Vision, Marion W. Hester
*Representatives to Industrial Council, P. G. Batson Jr.
Grievance, Duncan T. McEwan
Nursing, Thomas C. Kenaston
Blood, James N. Patterson
Medical Economics, Floyd K. Hurt
Commercial Health Insurance, Duncan T. McEwan
Medical Education and Hospitals, Thomas O. Otto
Resolution on Practical Nurse Education

(To Reference Committee No. 3)

Address of President, Ralph W. Jack
Board of Governors, Ralph W. Jack
Annual Joint Report of Secretary-Treasurer and Executive Director
*Necrology, Clifford C. Snyder
Advisory to Woman's Auxiliary, Sidney G. Kennedy, Jr.
*Councilor Districts and Council, Burns A. Dobbins, Jr.
Advisory to Selective Service, Corren P. Youmans
Civil Defense and Disaster, Corren P. Youmans
Advisory to Blue Shield, Robert E. Zellner
Medicare Mediation, Burns A. Dobbins Jr.
Editor of The Journal, Shaler Richardson
Resolution on Pension Fund for Physicians
Resolution on Interim Meeting
Resolution on Guarantee of Payment under Medicare

(To Reference Committee No. 4)

Legislation and Public Policy, H. Phillip Hampton
Mental Health, William M. C. Wilhoit
State Controlled Medical Institutions, William D. Rogers
Poliomyelitis Medical Advisory, Richard G. Skinner Jr.
Delegates to AMA
Revisions to Medical Practice Act
Resolution on Admissions to Veterans' Hospitals
Resolution on Merger of State Agencies
Resolution on House Bill 312
Resolution on Revisions to Medical Practice Act
Resolution on Involuntary Hospitalization for Mental Cases
*Supplemental report included

Dr. George W. Morse, Chairman, Cancer Control Committee, read a supplemental report which was referred to Reference Committee No. 1.

Dr. Marion W. Hester, Chairman, Conservation of Vision Committee, presented a supplemental report, which was referred to Reference Committee No. 2.

Dr. Jack Q. Cleveland of Dade: "As a member of the Committee on Medical Education and Hospitals, since Dr. Otto's report was not printed in the Handbook, I move that it be read before the House of Delegates."

Dr. Jack: "Dr. Cleveland, as Dr. Otto is not a delegate, the Chair would first have to have a motion that he be allowed the privilege of the floor."

Dr. Cleveland: "I move that he be allowed to come before the House of Delegates to read his report."

The motion was duly seconded and carried.

Following introductory remarks, Dr. Thomas O. Otto, Chairman, Committee on Medical Education and Hospitals, read his report which was referred to Reference Committee No. 2.

Dr. Robert E. Zellner, Chairman, Advisory to Blue Shield Committee, presented a supplemental report which was referred to Reference Committee No. 3.

Dr. Burns A. Dobbins Jr., Chairman, Medicare Mediation Committee, announced he was sorry that General Floyd L. Wergeland, Executive Director, Office for Dependents Medical Care, was not present to be introduced, that he had met with the Medicare Mediation Committee the previous evening but had had to return to Washington. He then presented the supplemental report of the Medicare Mediation Committee and showed slides to illustrate the statistics mentioned in the report. His supplemental report was referred to Reference Committee No. 3.

Dr. H. Phillip Hampton, Chairman, Committee on Legislation and Public Policy, read a supplemental report of his committee, which was referred to Reference Committee No. 4. The President then called on Dr. Edward R. Annis, who will take office as the new Chairman of the Committee on State Legislation, to present an additional supplemental report. Dr. Annis' report was referred to Reference Committee No. 4.

Dr. Jack: "The Chair deliberately changed the order in which the supplemental reports were read so that the two supplemental reports of the Board of Governors would be last."

Dr. Jack read the two supplemental reports of the Board of Governors, the first a resolution concerning H.R. 4700 and the second on The Florida Plan for Care of the Aged and Needy Sick. Both of these were referred to Reference Committee No. 4.

Dr. Jack: "Are there any additional reports or resolutions?"

Dr. DeWitt C. Daughtry of Dade presented a resolution on Emergency Medical Care, which was referred to Reference Committee No. 4.

Dr. Daughtry also presented a resolution on compulsory membership, which was referred to Reference Committee No. 3.

Dr. Anthony C. Galluccio of Broward presented a resolution on educating and encouraging the aged, which was referred to Reference Committee No. 2.

Dr. Harold W. Johnston of Orange, presented a resolution from the Orange County Medical Society on the adoption of a relative value scale. This resolution was referred to Reference Committee No. 3.

Dr. Francis T. Holland, Chairman, Medical Advisory Committee to the State Department on Public Safety, stated that he had been instructed by his committee to present a resolution recommending that county Committees on public safety be appointed. This resolution was referred to Reference Committee No. 3.

Dr. Ralph S. Sappenfield of Dade, presented a resolution on the term "cost of medical care," which was referred to Reference Committee No. 2.

Dr. Jack thanked the members who had presented resolutions and stated that if there were no more resolutions and no other business to be brought before the House, he had a couple of telegrams to read and announcements to make.

He read a telegram addressed to Dr. Francis T. Holland, representative from Florida to the World Medical Association from Dr. Louis H. Bauer, Secretary General. "Please present the greetings and best wishes of the World Medical Association and its United States Committee to the Florida Medical Association for a most successful meeting. The World Medical Association, which is the only representative the practicing doctors have on the international level, is constantly endeavoring to protect the standards of medical care, medical education and freedom in the practice of medicine."

Dr. Jack read another telegram received from Dr. Henry I. Fineberg, President, Medical Society of the State of New York. "Most sincere congratulations to you on completion of presidency of the Medical Association of Florida. Very best wishes to Leo M. Wachtel, M.D. on election and for a successful term. New Yorkers look forward to working together on problems of mutual interest."

Dr. Jack: "At this time, gentlemen, before we adjourn, I would like to call your attention to the work that is being done by our members on district and national levels. I don't think some of us stop to realize, sometimes, the great amount of work and participation by Florida physicians in organizations which have a great deal of effect on medicine and which do a great deal of good for the nation as well as the credit they bring to our state. In any such list there are bound to be some oversights. I know that all of these have not come to my attention and I wish to apologize beforehand for any oversights or omissions in this list and I would like any of you who know of any omission today to please give it to me on a slip of paper so that I can give that man recognition at the Monday meeting. First of all, on the AMA level, this is our year, of course, with our own Louis M. Orr of Orlando as President. As you all know, Dr. Homer L. Pearson of Miami is chairman of the Judicial Council; Dr. Francis T. Holland of Tallahassee has just gone on the Council on Rural Health; Dr. Reuben B. Chrisman Jr. of Coral Gables is a member of the Council on Legislative Activities and Council on Medical Service. He also serves on the AMA's committee on Maternal and Child Welfare. Dr. H. Phillip Hampton of Tampa has been an AMA Committee member on the Committee on Indigent Care. Dr. Edward H. Williams of Miami has served on the AMA Committee on Aging. Again, Francis T. Holland of Tallahassee has been a Florida representative on the Membership Committee of the World Medical Association and, also on world work, Ralph S. Sappenfield of Miami is American representative on the Executive Committee of the World Association of Anesthesiologists.

"Dr. Walter W. Sackett Jr. of Miami has just been elected to the Board of Directors of the American Academy of General Practice, and Dr. Leo M. Wachtel of Jacksonville is a member of the Commission on Hospitals of the American Academy of General Practice. Dr. James H. Ferguson of Miami has been chairman of the Public Relations Committee of the American College of Obstetricians and Gynecologists and is the newly elected section chairman for the State of Florida for that organization. Dr. John D. Milton of Miami is the newly elected section vice chairman. Dr. DeWitt C. Daughtry of Miami is on the Board of Directors of the National Tuberculosis Association. He is also president-elect of the Southern Chapter of the American College of Chest Physicians. Dr. Clifford C. Snyder of Miami is Secretary of the American Association of Plastic Surgeons."

Dr. Day: "Here's one more: Dr. Ralph W. Jack this week completed the second vice presidency of the American College of Obstetricians and Gynecologists. He is a member of the Executive Board and vice chairman for District 4, Southeastern United States.

Dr. Jack: "Thank you, Sam. One additional announcement and that is a request that you all remain for the Blue Shield Meeting which will convene here immediately following our recess.

"I am going to take just a half minute more of your time. I came directly here from the meeting of the American College of Obstetricians and Gynecologists in Cincinnati. I had a good opportunity to read the Cincinnati newspapers and I think in view of some of the remarks made here today and since I feel that this fits in very well with some of the views and words that I said myself, I wish to read an editorial from the Cincinnati Enquirer from last Sunday, April 3rd written by Otto Garr Tague.

Wake Up, Americans!

By Otto Garr Tague

Are you one of those rocking-chair citizens who are too indifferent or too indolent to become informed on the doings of the Communists and their stooges among us in their efforts to subvert our form of government into something to resemble the type advocated by Marx and Lenin? . . . If so, I have news for you . . . It is this:

Unless you soon become active in the preservation of the nation you profess to love, you could be headed toward a concentration camp in Siberia not too long from now . . . where you would find many thousands of men and women from other countries who sat around in their rocking chairs until it was too late to do anything to stop it.

You don't believe this? . . . Then you just do not know what is going on all around you . . . How many thousands of your fellow citizens are actively engaged in helping the Communists to take this nation over . . . Nor do you realize the extent to which these agents of subversion have penetrated activities of our people—in our defense plants, churches, schools, labor unions and commerce institutions . . . And until you do become informed in this respect, how can you hope to be of help in preserving your nation?

It's later than you think—Wake Up, Americans!

The House of Delegates recessed at 4:35 p.m. to reconvene at 2:00 p.m. on Monday, April 11, 1960.

Second House of Delegates

The House of Delegates reconvened at 2:10 p.m. on Monday, April 11, 1960, in the Windsor Room North of the Hotel Robert Meyer, Jacksonville, Florida, with President Ralph W. Jack presiding.

Dr. Evans: "Mr. President, I would like to report that there are now registered 153 delegates, making a quorum of the House for the purpose of transacting business, and I move that the delegates be seated."

The motion was duly seconded and carried.

Delegates

ALACHUA—Henry J. Babers Jr., F. Emory Bell, Eugene H. Cummings, Walter E. Murphree

BAY—William C. Roberts *(Absent—Sidney E. Daffin)*

BREVARD—James R. Doty, Theodore J. Kaminski, Thomas C. Kenaston, Arthur C. Tedford

BROWARD—Miles J. Bielek, Alexander H. Bluestone, Fred E. Brammer, Russell B. Carson, Donald H. Gahagen, Anthony C. Galluccio, Walter J. Glenn Jr., Russell R. Hippensteel, Robert J. Patterson, Leigh F. Robinson, Randall W. Snow, W. Dotson Wells, Scottie J. Wilson.

CHARLOTTE—*(Absent—Carl N. Reilly)*

COLLIER—*(Absent—Daniel B. Langley)*

COLUMBIA—Laurie J. Arnold Jr.

DADE—James L. Anderson, Edward R. Annis, Jack Q. Cleveland, Vincent P. Corso, Edward W. Cullipher, DeWitt C. Daughtry, Robert F. Dickey, L. Washington Dowlen, Franklin J. Evans, Willard L. Fitzgerald, M. Eugene Flipse, Thomas S. Gowin, Harold O. Hallstrand, W. Tracy Haverfield, R. Spencer Howell, James J. Hutson, Paul S. Jarrett, Walter C. Jones, Christian Keedy, Robert P. Keiser, Donald F. Marion, John D. Milton, Warren W. Quillian, Hunter B. Rogers, Walter W. Sackett Jr., Ralph S. Sappenfield, Donald W. Smith, Clifford C. Snyder, Franz H. Stewart, Joseph S. Stewart, Collins W. Swords Jr., Charles F. Tate Jr. *(Absent—Julius Alexander, Morris H. Blau, John E. Burch, Turner E. Cato, Richard C. Clay, Francis N. Cooke, H. Clinton Davis, Raymond L. Evans, Richard M. Fleming, Milton S. Goldman, Maurice M. Greenfield, Morton M. Halpern, Thomas W. Hutson Jr., David Kirsh, George F. Schmitt Jr., Nelson Zivitz)*

DESOTO-HARDEE-GLADES—*(Absent—Gordon H. McSwain)*

DUVAL—Sullivan G. Bedell, James L. Borland, Frederick H. Bowen, Robert J. Brown, Hugh A. Carithers, Emmet F. Ferguson Jr., Floyd K. Hurt, Gordon H. Ira, Edward Jelks, Joseph J. Lowenthal, Charles F. McCrory, Kenneth A. Morris, A. Sherrod Morrow, John T. Stage, Sidney Stillman, G. Dekle Taylor, Ashbel C. Williams. *(Absent—J. K. David Jr.)*

ESCAMBIA—Egbert V. Anderson, Herbert L. Bryans, Luther C. Fisher Jr., Sidney G. Kennedy Jr., George W. Morse, Walter C. Payne Sr.

FRANKLIN-GULF—John W. Hendrix

HIGHLANDS—Donald C. Hartwell

HILLSBOROUGH—Samuel H. Adams, William C. Blake, Ernest R. Bourkard, C. Frank Chunn, Herschel G. Cole, H. Phillip Hampton, Samuel G. Hibbs, David R. Murphey Jr., James N. Patterson, Wesley W. Wilson. *(Absent—Herbert B. Lott, William R. Rowlett)*

INDIAN RIVER—*(Absent—Erasmus B. Hardee)*

JACKSON-CALHOUN—James T. Cook Jr.

LAKE—Frederick C. Andrews. *(Absent—C. McK. Tyre)*

LEE-HENDRY—*(Absent—Fred D. Bartleson, H. Quillian Jones)*

LEON - GADSDEN - LIBERTY - WAKULLA - JEFFERSON—T. Bert Fletcher Jr., Nelson H. Kraeft, Robert H. Mickler. *(Absent—George S. Palmer)*

MADISON—Thomas G. Bouland Jr.

MANATEE—Irving E. Hall Jr., Richard V. Meaney

MARION—William H. Anderson Jr., Eugene G. Peek Jr.
MONROE—Ralph Herz
NASSAU—B. Joe Wilder
ORANGE—Louis P. Brady, Norman F. Coulter, Harry H. Ferran, Truett H. Frazier, Harold W. Johnston, Carl S. McLemore, Fred Mathers, Charles R. Sias, W. Dean Steward, Robert L. Tolle, Robert E. Zellner. *(Absent—Louis C. Murray, Miles W. Thomley)*
PALM BEACH—Willard F. Ande, James F. Cooney, C. Jennings Derrick, V. Marklin Johnson, Ralph M. Overstreet Jr., Cecil M. Peek, William H. Proctor. *(Absent—Walter R. Newbern, S. Richard Ombres, Younger A. Staton)*
PASCO-HERNANDO-CITRUS—S. Carnes Harvard
PINELLAS—Clyde O. Anderson, Elmer B. Campbell Sr., Chas. L. Farrington, N. Worth Gable, Francis H. Langley, George H. Schoetker, Walter H. Winchester. *(Absent—Edward L. Cole Jr., John P. Ferrell, Earl R. Fox, Jack A. MaCris, Norval M. Marr Sr., J. Braden Quicksall, John P. Rowell, Robert T. Walker, Rowland E. Wood)*
POLK—Clarence L. Anderson, Samuel J. Clark, John E. Daughtrey, Newell J. Griffith, Marion W. Hester, Charles Larsen Jr. *(Absent—Arthur J. Moseley Jr.)*
PUTNAM—Fairfax E. Montague
ST. JOHNS—Herbert E. White
ST. LUCIE-OKEECHOBEE-MARTIN—John M. Gunsolus, Richard F. Sinnott
SARASOTA—John M. Butcher, Karl R. Rolls, Melvin M. Simmons, Millard B. White. *(Absent—Samuel E. Kaplan)*
SEMINOLE—Vann Parker
SUWANNEE-HAMILTON-LAFAYETTE — Shirley L. Hadden
TAYLOR—Walter J. Baker
VOLUSIA—Thomas D. Cook, Peter A. Drohomer, Theodore F. Hahn Jr., Herbert D. Kerman, Achille A. Monaco *(Absent—William W. Schildecker)*
WALTON-OKALOOSA-SANTA ROSA — Frederick F. Crews, Eric F. Geiger
WASHINGTON-HOLMES—*(Absent—Walter H. Shehee)*
STATE OFFICERS—Ralph W. Jack, Leo M. Wachtel, Eugene B. Maxwell, Henry L. Harrell, Jere W. Annis, Samuel M. Day.
AMA DELEGATES—Reuben B. Chrisman Jr., Francis T. Holland, Burns A. Dobbins Jr., Meredith Mallory.

Dr. Jack: "Our first order of business for this afternoon will be the presentation of life membership certificates. Our secretary, Dr. Day, will read the names of these men.

Dr. Day: "It is always good to be able to recognize those who have given service to our organization over a long period of years. As you know, life membership entails 35 years of membership in our Association."

Lowrie W. Blake	Bradenton
Sanford C. Colley	Tavares
Joseph B. Davis	Daytona Beach
Stephen A. Dawson	St. Petersburg
Horace A. Day	Orlando
M. Jay Flipse	Miami
Frank L. Fort	Jacksonville
Ralph James Greene	Perry
Robert M. Harris	Miami
Isaac M. Hay	Melbourne
Merle C. Kayton	Wauchula
John G. Lester	Lakeland
R. Gaylord Lewis	West Palm Beach
Sherrod A. Lindsey	Fort Meade
William D. Lithgow	Miami
Whitman C. McConnell	St. Petersburg
E. Norton McKenzie	Miami
William W. McKibben	Coral Gables
Alvin L. Mills	St. Petersburg
Homer L. Pearson Jr.	Miami
Thomas G. Simmons	Auburndale
John W. Snyder	Miami
William C. Thomas Sr.	Gainesville
John C. Turner Sr.	Miami
Ernest W. Veal	Jacksonville
Sterling E. Wilhoit	Tallahassee
Corren P. Youmans	Miami

Dr. Jack: "I have a special honor this afternoon, an honor that no president of the Florida Medical Association has ever before had, the privilege of bringing before you not only the President of the American Medical Association, but he is a member of the Florida Medical Association and a member of this House of Delegates. I don't need to say any more—Dr. Louis M. Orr."

(Dr. Orr's address will be found on page 1488 of this issue)

Dr. Jack: "It has been a happy occasion for me, as your president, to bring you the messages you have heard in the few days we have been here. I hope you will take them home and tell the other doctors about them.

"We will now have the reports of our Reference Committees."

Report of Reference Committee No. 1

Health and Education

Dr. Robert L. Tolle: "Mr. President and members of the House of Delegates: Your Reference Committee on Health and Education, composed of Drs. Sidney Stillman, John M. Butcher, Miles J. Bielek, Hunter B. Rogers and myself as Chairman, considered the reports of the various committees and make the following report:

"The report of the Committee on Scientific Work, presented by Dr. Thad Moseley, Chairman, is approved as printed in the Handbook.

"Mr. President, I move the adoption of this portion of the report."

Motion was seconded and carried.

Report of Committee on Scientific Work

THAD MOSELEY, *Chairman*

Upon June 28, 1959, your Scientific Work Committee proposed to the Board of Governors of the Florida Medical Association that at the 1960 Annual Meeting to be held in Jacksonville, the Scientific Work Committee cooperate with the special interest groups in obtaining speakers of especial merit for presentation at the general scientific assemblies. It also proposed to transfer the dates of the 1960 meeting so that they would encompass Friday, Saturday, Sunday and Monday. The Board unanimously approved both proposals and set the dates for the 1960 Annual Meeting as April 8 through 11, 1960.

Upon September 13, 1959, at a called meeting of the officers of the special interest groups, presided over by Dr. Ralph Jack, President of the Florida Medical Association, these groups voted unanimously to cooperate in obtaining men of outstanding merit for presentation at the 1960 Florida Medical Association meeting.

With excellent cooperation from all persons involved, the 1960 scientific program is now completed, with the First Scientific Assembly to be upon Saturday morning, April 9; the second, Saturday afternoon, April 9, and the third, Monday morning, April 11, 1960.

Dr. Tolle: "The report of the Committee on Medical Postgraduate Course, presented by Dr. Donald F. Marion, Chairman, is approved; however, the Reference Committee is of the opinion that the wording in the second paragraph on page 17 of the Handbook, should be changed. We recommend the deletion of the words 'sort of'.

"Mr. President, I move the adoption of this portion of the report as amended."

Motion was seconded and carried.

Report of the Committee on Medical Postgraduate Course

DONALD F. MARION, *Chairman*

During the past year a beginning has been made in the projected extension and alteration of the activities of the Committee on Medical Postgraduate Course. More courses and better courses are being planned and presented each year in Florida. Led by newly-created divisions of postgraduate education in the two medical schools, larger hospitals and affiliated hospital groups have increasingly broadened the scope of their community service by sponsorship of one or more seminars or symposia each year. Many of these are impressive in their size and scope, and most bring one or more world-leaders in special scientific categories to our state. Rapid growth such as this has already led to a crowded calendar. Before long it appears likely that scheduling difficulties may lead to some degree of overlapping and even reduplication within the same areas.

The idea of the Committee on Medical Postgraduate Course serving as a clearing house in the future has met with encouragement from nearly all of the existing sponsoring agencies. Assistance has been volunteered by the editors of all state and county publications devoted to Medicine, looking toward a regular all-inclusive and dependable section devoted to postgraduate education opportunities throughout the state. To become useful as a scheduling reference, the committee will no doubt require some record-keeping and secretarial assistance from the Florida Medical Association Headquarters. It is unlikely that this will ever become either burdensome or expensive, however.

During 1959 and 1960 announcement of nearly all courses and seminars reached the Committee well in advance of first publication. In several instances correspondence resulted in agreement upon changes in projected scheduling which resulted in larger attendance. This is a committee activity which should be expanded and improved.

The Committee has received invitations from several sponsoring agencies to suggest types of courses and programs to be presented in future. Comment and criticism of current presentations have also been requested of the Committee. Thus far, the Committee has not ventured in this direction, believing that specific qualifications for such suggestions and criticisms should be apparent in each member of the Committee, and doubting that time and circumstances now permit participation in planning or even attendance at a majority of the courses. This may be a committee activity in future. If it should appear to be desirable, it is likely that the committee membership should be enlarged and that some experts in the field of postgraduate medical education should be asked to serve either as members or as advisors.

Dr. Tolle: "The report of the Committee on Venereal Disease Control, presented by Dr. C. W. Shackelford, Chairman, is approved; however, the Reference Committee is of the opinion that the third paragraph beginning 'According to Bay County,' need not appear in The Journal.

"Mr. President, I move the adoption of this portion of the report as amended."

Motion was seconded and carried.

Report of Committee on Venereal Disease Control

C. W. SHACKELFORD, *Chairman*

There were no Committee meetings during the year. There have been none since I became a member several years ago. All the members were contacted by mail and each responded, contributing much to the compiling of this report.

Your 1959 Committee reported a vast decline in the incidence of Venereal Disease over a period of ten years. However, reported cases of Venereal Disease in Florida for 1958 and 1959 by All Syphilis, Lesion Syphilis, and All Other V. D. were:

	All Syphilis			Primary and Secondary Syphilis			Gonorrhea and Other V. D.		
			%			%			%
	1958	1959	Change	1958	1959	Change	1958	1959	Change
All Sources	3186	4332	36.0	201	344	71.1	10495	11437	9.0
Private Physicians	1619	2248	38.8	49	90	83.7	Change not Significant		

The Florida State Board of Health and Health Officers of its component counties are making special efforts to locate venereal disease contacts. They have trained venereal disease investigators who interview all known cases in an effort to run down all contacts.

We believe the Health Departments are doing a good job, and with the full cooperation of all private practicing physicians, which means prompt reporting to health officers all V. D. cases and those they treat, treat adequately to cure before being dismissed, the menace of venereal disease in Florida should not be a big problem.

Dr. Tolle. "The report of the Committee on Maternal Welfare, presented by Dr. J. M. Ingram Jr., Chairman, is approved; however, it is recommended that the wording of the fourth paragraph be changed to read, 'In October, this Chairman met with the Bureau of Child Health and the Public Health Nursing Committee of the State Board of Health,' etc.

"Mr. President, I move the adoption of this portion of the report as amended."

Motion was seconded and carried.

Report of Committee on Maternal Welfare

J. M. INGRAM JR., *Chairman*

The Maternal Welfare Committee held one meeting, on Jan. 31, 1960, at Hollywood Beach, to plan the Obstetric-Pediatric Seminar for the coming August. A second meeting will be held at the Seminar.

Working with the Boards of Health of Florida, Georgia, South Carolina and Alabama, the Committee sponsored the Ninth Postgraduate Obstetric-Pediatric Seminar at Ellinor Village, Daytona Beach, on Aug. 20-22, 1959. We were fortunate in inheriting this year's program, already planned and organized, from the former chairman, Dr. Frank McCall. Much credit is due Dr. McCall for his tireless efforts in organizing the Seminar for the past nine years. Registration this year was 467, breaking all previous records. The quality of the speakers has been reflected in the steady yearly increase in registration.

The maternal mortality rate for Florida, through September, 1959, was 5.5 per 10,000 live births, as compared with the national average of 4.5 per 10,000. This year the white mortality rate dropped from 2.9 to 2.4. The colored rate increased from 13.4 to 14.0. Therefore our major efforts were directed toward reducing the colored mortality.

In October, this Chairman met with the Bureau of Child Health and with the Public Health Nursing Committee of the State Board of Health in Jacksonville, to aid them in defining plans for reduction in the colored mortality. In this, and in a second meeting in December, the following plans were made and were recommended to the Health Officers Conference:

(1) More frequent hospital delivery of colored mothers.
(2) Improved training of midwives.
(3) More intensive study of maternal deaths and perinatal deaths.

It was obvious that midwives are essential to sparsely populated counties with few physicians and few hospitals. They have little function in densely populated counties with adequate hospitals and resident training programs. For the present, each county must regulate its own midwives.

The attention of the House is respectfully asked to the predicted hundred per cent increase in the national birth rate by 1970. Because of the great shift in population, the increase in Florida in this decade will be much greater. This will impose more burden on the already overtaxed hospitals of the state. The first and greatest burden will fall on the obstetric and pediatric services. It is essential that immediate planning be done in each community for the rapid expansion of obstetric and pediatric facilities.

This Committee, together with the Bureau of Maternal and Child Health, recommends that it be granted permission to establish a uniform system of analysis of each maternal death in the state, and that these analyses be classified as preventable or nonpreventable by the Committee or by a group appointed for that purpose. Such plans have proved of great value in other states.

Our deep appreciation is expressed to the Board of Health of each state participating in the Seminar, to Dr. Sowder, Dr. Doff, Dr. Alexiou, and to the Florida State Board of Health.

Dr. Tolle: "The report of the Committee on Child Health, presented by Dr. Warren W. Quillian, Chairman, including the two resolutions, is approved as printed in the Handbook.

"Mr. President, I move the adoption of this portion of the report."

Motion was seconded and carried.

Report of Committee on Child Health

WARREN W. QUILLIAN, *Chairman*

During the past year your Committee has felt that its most effective function was in advising and providing guidance for the respective state agencies on matters pertaining to school health, and in helping to formulate long range policies for the school health program. Having been designated by the President and Board of Governors of the Florida Medical Association as a medical advisory committee to the State Department of Education and to the Board of Health, we have had several joint meetings in Jacksonville at the F.M.A. headquarters. The standards and programs for betterment of the health of school children in Florida are excellent, but many problems arise in their administration. It has been felt that the solution of many lies in cooperative effort by county medical society committees on school health who are serving in an advisory capacity with the school administration, county superintendents, Board of Health and Parent-Teacher organizations in matters pertaining to school health. Many allied groups are involved in efforts to maintain high standards at a local level. Physicians should be leaders in these efforts. The fine spirit of cooperation exhibited by leaders among the fields of education and of public health has been most heartening.

Feeling that a medically supervised eye-screening test should be adopted in all the schools of Florida, your Committee has worked in close harmony with the Committee on Conservation of Vision, under the able leadership of Dr. Marion Hester, Chairman. The latter has attended two of our joint sessions, and presented some of the problems confronting them in their efforts. Certain recommendations have been made concerning controversial issues which have arisen as to what constitutes a good, practical eye-screening program for the schools. The F.M.A. House of Delegates approved the program as outlined by the Committee on Conservation of Vision in May 1959. In local areas, due to aggressive efforts by paramedical groups and certain civic organizations, this program has not been universally adopted. It is hoped that the physicians of Florida will acquaint themselves with the facts and needs in this respect within their own communities to implement the program for uniform standards with a sound realistic policy.

Efforts have been made to create a general awareness of the need for adequate immunization and regular physical examinations. The Florida State Board of Health prepared material for public radio and television broadcasting (reviewed and endorsed by the Committee on Child Health) for distribution during August by the local radio and television stations.

A summer fitness conference at Miami Beach in July was sponsored by the Florida Association for Health, Physical Education and Recreation with the cooperation of the State Department of Education. The Chairman of your Committee on Child Health was invited to participate in this conference designed to develop recommenda-

tions for improving the areas of work concerned with safety education, physical and health standards, intramural athletics and summer programs of recreation. The entire conference report, dealing with suggestions for improvement of the school health program is available to members of the F.M.A. who are interested.

Major emphasis has been placed upon encouragement of active school health programs within the counties. The success of any such program depends upon the interest and active leadership of the physicians of the State. Certain resolutions adopted by the Committee on Child Health and approved by the Board of Governors are attached herewith as a part of this report.

Resolution

Committee on Child Health

WHEREAS, The Florida Medical Association considers the development of an adequate school health program in Florida of extreme importance to the acquisition and maintenance of optimum health on the part of young people; and

WHEREAS, The Florida Medical Association has indicated its interest in this development by recommending the establishment of a School Health Medical Advisory Committee to the Florida State Department of Education and the Florida State Board of Health; and

WHEREAS, The State Department of Education and State Board of Health under the leadership of Superintendent Thomas D. Bailey and State Health Officer Dr. Wilson T. Sowder have been commended by the Florida Medical Association for their intensive efforts to improve the school health programs throughout the state by the implementation of the Health Coordinator Plan and other efforts to improve the school health program which are bringing about encouraging results as indicated by the increased interest and concern on the part of county school leadership; and

WHEREAS, It is recognized that a large and difficult task lies ahead to overcome practical problems, deal with controversial issues and bring about public support and understanding; therefore be it

RESOLVED, That the Florida Medical Association pledge its support and cooperation to the end that an outstanding school health program be developed in Florida; and be it further

RESOLVED, That this program should be conducted in keeping with the recommendations of the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association and the reports of the National Conference on Physicians and Schools; and be it further

RESOLVED, That the Florida Medical Association and its members recognize their responsibility to advise and participate in efforts to bring such a program into being; and be it further

RESOLVED, That local medical societies be requested to join with local public school and public health officials for the purpose of establishing Advisory Committees on School Health in counties where no such committees exist.

Adopted Sept. 27, 1959

Resolution

School Health Medical Advisory Committee to the Florida State Department of Education and Florida State Board of Health

WHEREAS, It is recognized that there has developed an increased popular interest in the improvement of health and fitness of children and youth; and

WHEREAS, This interest is evidenced by an increasing number of organizations initiating activities directed toward the school health program; and

WHEREAS, The State Department of Education and the State Board of Health share joint responsibility for the health of children in public schools; and

WHEREAS, The need is recognized for a sound statewide policy which will assure the children of Florida the finest possible health care and services available; therefore be it

RESOLVED, That county school boards consider requests from interested organizations for health-related activities and programs within the public schools only after full consultation with their local county health department and its appropriate medical advisory groups.

Adopted Sept. 27, 1959.

Dr. Tolle: "The report of the Liaison Committee to the State Board of Health, presented by Dr. James T. Cook Jr., Chairman, is approved as printed in the Handbook, including the recommendation that the committee be discontinued.

"Mr. President, I move the adoption of this portion of the report."

Motion was seconded and carried.

Report of Liaison Committee to the State Board of Health

JAMES T. COOK JR., *Chairman*

This Committee has met in accordance with the directives of the House of Delegates. The first meeting was held on Aug. 9, 1959 in Jacksonville at which time a questionnaire was proposed and prepared, to determine the points of friction between the Florida Medical Association or its individual members and the State Board of Health or its individual members. This questionnaire was sent to each component county medical society, of which 47% replied. The results of the questionnaire are on file at the Association's office, and will be available to the reference committee and the House of Delegates.

Following this, another meeting was held Feb. 9, 1960. This meeting was in conjunction with the annual meeting of the Health Officers Association, and at this time the results of the questionnaire were discussed. In addition, a round table forum with the health officers was conducted under the guidance of this committee and a one hour discussion on the subject of the maintenance of good relations between the State Board of Health and private physicians was presented by the committee later in the afternoon.

In reference to the resolution adopted by the 1959 House of Delegates, the committee has the following comments on each item:

1. The committee has met with and been gracefully received by Dr. Sowder. In view of very slow reception of answers and practically no grievances being received, quarterly meetings were neither feasible nor necessary.
2. The Health Department discourages the use of dangerous injections except in the presence of a physician. They are intensely aware of the dangers of anaphylaxis. Occasional violations have occurred.
3. Those answering the questionnaire, the doctors of the Board of Health, and the members of this committee, are all unanimous in their opinion that the Code of Ethics of the AMA should govern the actions of the county health physicians, and a separate code would be redundant and obnoxious to these doctors, who consider themselves physicians just as we are.
4. Centralization of control is not recommended. All societies who replied desire local control.
5. The committee feels that its meetings with Dr. Sowder and the public health officers have been of great advantage to both parties.
6. This report.

In summary, the committee feels that relations between the State Board of Health and the members of the FMA are excellent. Points of friction are at a minimum. The Board of Health is very cooperative.

The committee would like to stress and encourage close liaison between component county societies and their own local health departments. It is the committee's feeling that almost all points of friction can be resolved in advance with this type of cooperation.

In addition, the committee feels that continuation of this committee is unnecessary and recommends its discontinuance. Any member, or any component county medical society, having grievances against the State Board of Health has the following points of recourse:

(a) Local society
(b) FMA Committee on Liaison with State Agencies
(c) Medical members of the State Board of Health
(d) Board of Governors of the FMA

Dr. Tolle: "The report of the Committee on Tuberculosis and Public Health, presented by Dr. M. Eugene Flipse, Chairman, is approved as printed in the Handbook.

"Mr. President, I move the adoption of this portion of the report."

Motion was seconded and carried.

Report of Committee on Tuberculosis and Public Health

M. EUGENE FLIPSE, *Chairman*

The Tuberculosis and Public Health Committee maintained close effective working relationships with the official and voluntary health agencies of the State interested in the prevention and control of tuberculosis; namely, the Bureau of Preventable Diseases, Florida State Board of Health, Tuberculosis Board, and the Florida Tuberculosis and Health Association.

The Committee held one emergency meeting to investigate and then take strong issue with certain derogatory remarks made against the State Tuberculosis Board in regard to the care of patients at the Southeast Florida Tuberculosis Hospital in Lantana by a disgruntled employee.

Dr. Tolle: "The supplemental report of the Committee on Tuberculosis and Public Health is approved as presented.

"Mr. President, I move the adoption of this portion of the report."

Motion was seconded and carried.

Supplement

More attention is being given to the health of our citizens and the amount of illnesses. There have been various estimates made of the number of cases of chronic diseases such as cancer, heart disease, arthritis, diabetes and other conditions. The physician is accustomed to reporting communicable diseases to the local health department but is not expected nor required to report the diseases listed above.

In order to secure a more accurate estimate of the number of cases of chronic diseases it is proposed that sample surveys be made by the State Board of Health in Florida in a few selected counties. These surveys would be done by securing the approval of the county medical societies first and asking the individual physician to keep a record of all new cases seen for a short period of time. Such surveys would provide valuable information on the prevalence of chronic diseases. It is recommended that it be approved.

Dr. Tolle: "The report of the Committee on Cancer Control, presented by Dr. George W. Morse, Chairman, is approved as printed in the Handbook.

"Mr. President, I move the adoption of this portion of the report."

Motion was seconded and carried.

Report of Committee on Cancer Control

GEORGE W. MORSE, *Chairman*

During the past year, two tumor clinics have been added to the state of Florida, one at Fort Myers and one at Gainesville, giving us now 21 tumor clinics. It is estimated that 20,700 patients were seen as compared to 18,921 in 1958. A check of the reports indicates that approximately three-fourths of the new patients reporting during the year have been positive for cancer. Despite the fact that we have been increasing our tumor clinics, it must again be emphasized that cancer control must start in each doctor's office. A recent study of vital statistics by the State Board of Health indicates that for 1958 in the Florida female cancer was the leading cause of death in the age group of 35-44 and 45-54. Here is adequate justification to encourage all out cervical cytological examinations and to insure that most women get an opportunity to learn about breast self-examinations as over one-third of the cancer in women in Florida is found in the uterus and the breasts.

We should like to also request all members of the Association who may have an occasion to address our teenagers to emphasize the casual relationship between smoking and lung cancer which appears to be well founded but not significantly impressed upon the younger adult population of our state.

Liaison between this Committee and the Cancer Council has been excellent. In October 1959 your representatives on the Florida Cancer Council approved a cervical cytological screening for the medically indigent of Dade County. If this project should be successful, it is hoped that there will be extension of this project to the rest of the state.

Dr. Tolle: "The supplemental report of the Committee on Cancer Control is approved in principle; however, the Reference Committee is of the opinion that this survey would prove repetitious, inasmuch as the aforementioned Supplemental Report of the Committee on Tuberculosis and Public Health, which has been approved, offers a complete chronic disease survey, including cancer.

"Mr. President, I move that this portion of the report be disapproved."

Motion was seconded and carried.

"Mr. President, I move the adoption of this entire report, as amended."

Motion was seconded by Dr. Ralph Herz and carried.

Report of Reference Committee No. 2

Public Policy

Dr. Edward R. Annis: "Mr. President and members of the House of Delegates: Your Reference Committee No. 2, consisting of Drs. Henry J. Babers Jr., Clyde O. Anderson, W. Dean Steward, Eugene G. Peek Jr. and myself as Chairman, gave careful consideration to the items referred to it and makes the following report:

"Report of Committee on Conservation of Vision and Supplement, by Dr. Marion W. Hester, Chairman. We approve and commend the efforts of the Committee on Conservation of Vision, which is continuing its present program of attempting to install a uniform, medically supervised program of eye screening in all of the elementary schools of Florida.

"We also approve the supplement recommending that our county medical societies encourage activities in cooperation with local ophthalmologists, county health officers and lay groups, in the newly developed health field of surveys to uncover early and undetected chronic glaucoma. The Committee strongly recommends that the ophthalmologists give more than passive support to assure the success of these and similar programs.

"Mr. President, I move the adoption of this portion of the report."

Motion was seconded and carried.

Report of Committee on Conservation of Vision

MARION W. HESTER, *Chairman*

The Committee is continuing in its program of attempting to install a uniform, medically supervised program of eye screening in all the elementary schools of the state of Florida. This program is following the pattern of a pilot plan which is in its second year of operation in Polk County. Recommendations made by the Florida Society of Ophthalmology and Otolaryngology and adopted by the House of Delegates of the Florida Medical Association in 1958 are being followed. Programs are carried out by the County Health Departments using full time paid technicians. These technicians are trained by your Committee and work under committee and county medical society supervision. The equipment used is the Atlantic City Test. At the beginning of the present school year, the State Board of Health purchased fifty testing units for resale at a reduced price to the local county health departments.

The Committee has attempted to have the eye screening program installed in as many county school systems as possible. To encourage this, instruction material has been mailed from the Florida Medical Association headquarters and the State Board of Health headquarters to presidents and secretaries of all county medical societies and to all county health officers. In July 1959, the booklet "Identification of Children Requiring Eye Care" was mailed. This is a comprehensive survey of the subject and represents the best current medical thinking. In early September 1959, a memorandum summarizing committee recommendations on eye screening and offering help and advice in setting up local programs was mailed. Included with this memorandum were committee summaries "Selection of Eye Screening Apparatus For Use in Schools" and instruction sheets "Use of the Atlantic City Test."

On Sept. 10, 1959, your Committee chairman met with the Florida Medical Association Committee on Child Health acting in its capacity as School Health Medical Advisory Committee to the State Department of Education and the State Board of Health. This meeting was at the Florida Medical Association Offices in Jacksonville.

On Feb. 9, 1960, members of this Committee attended a meeting of the Florida State Board of Health and Florida Health Officers Association in Jacksonville. A delegation from the Florida Optometry Association had asked for a conference with the State Board of Health to discuss problems of eye screening in schools. Dr. Sowder, State Health Officer, had requested members of the Florida Medical Association Committee on Conservation of Vision to attend this conference in an advisory capacity to the State Board of Health.

The Committee feels that real progress has been made in the program of school eye screening but much work lies ahead in making the plan statewide and we urgently request the support of the component county medical societies in instituting this program in all the county school systems.

Supplement

The Committee on Conservation of Vision has had several requests from different lay organizations for help in establishing glaucoma detection programs by mass public screening tests. In three urban areas of the state such programs have already been conducted. Two of these have been done on a limited basis but one has been a large and continuing program. In at least six other urban areas of the state such programs have been proposed for the immediate future.

Surveys indicate about 2 to 3% of our population have undetected chronic glaucoma. Untreated chronic glaucoma of long duration usually results in serious loss of vision or blindness. The public and several civic, and fraternal and sorority groups are becoming increasingly aware of the importance of early detection of this disease. This awareness and interest have created a desire among these lay groups to organize and participate in glaucoma detection programs throughout the state. One state civic organization, the Florida Lions Foundation, has requested specific help from this committee, the Florida Medical Association and the Florida Society of Ophthalmology and Otolaryngology. This group has requested medical guidance and supervision in carrying out these plans. This group has requested: (1) An outline of necessary procedures or examinations to be used, (2) Recommendations of the type and amount of equipment needed for the tests and (3) Help in obtaining personnel to carry on the various programs. This group proposes to activate mobile units for glaucoma detection in rural areas and anticipates that staffing such mobile units will be their hardest problem to solve.

This committee recognizes that this surge of public interest is such that many of these programs will be established in our state. This will probably take place with or without the active interest and participation of organized medicine. If ophthalmologists do not participate

or give only passive support to these programs, optometrists and other non-medical groups will probably soon be in control.

Realizing the grave consequences of untreated glaucoma and the opportunity open at present for active medical leadership in a newly developing health field, this committee recommends active participation by the Florida Medical Association in this field.

It is recommended that the Florida Medical Association and the component county medical societies supply supervision, guidance and aid to reliable lay groups who wish to conduct glaucoma detection programs. Such participation will usually best be accomplished as a joint effort by the county medical society and the county health officer. In urban areas one ophthalmologist or a committee of ophthalmologists should be named to supervise the programs. In rural areas, definite arrangements should be made with one of the nearest ophthalmologists for training personnel and for any needed advice and help.

The Committee recommends that the amount and type of screening testing, the methods of conducting the tests, and the amount and type of equipment used, should be determined by current recommendations from the Florida Society of Ophthalmology and Otolaryngology.

Dr. Annis: "The report of the Committee on Representatives to Industrial Council and Supplement, by Dr. P. G. Batson Jr., Chairman. The Committee reviewed at length this report and its supplement, and the work of the Committee on Representatives to the Industrial Council, including additional comments at the Reference Committee meeting. We recommend approval of the report as printed in the Handbook with the exception of subsection 'B' on page 27, the reason being that at the last moment this morning at the time the Committee met we had a different view presented by the anesthesiologists. It is our feeling that this should go back to the initial committee. With this exception, Mr. President, we recommend approval of this portion of the report."

Motion was seconded and carried.

Dr. Annis: "Continuing the report of the Committee on Representatives to Industrial Council, and representing some of the problems which are faced by representatives of your Association, it was reported to the Reference Committee that the Associated Industries of Florida, through their representative, claim that they have a list of 50 doctors who are satisfied with the present fee schedule and will continue to use it, even if the fees should be elevated as a result of negotiations.

"In an effort to clarify the situation, the Committee on Representatives to Industrial Council sent out a questionnaire to the 39 county medical societies; only 16 societies have returned this questionnaire. The information requested on the questionnaire is vital to the work of the committee, in that it attempts to determine the usual and regular charges made by physicians in industrial cases in the different areas of the state.

"The Committee on Representatives to Industrial Council has previously been empowered by the House of Delegates to act for the Association, but the efficiency of its work and the success of its ultimate objectives will parallel the cooperation received from the county societies, and especially from the individual members, who should be vitally interested.

"Mr. President, I move the adoption of this portion of the report."

The motion was seconded and carried.

Report of Committee on Representatives to the Industrial Council

P. G. BATSON Jr., *Chairman*

In compliance with authority vested by action of the House of Delegates at the time of the Annual Meeting of the F.M.A. in May 1959, the Committee has worked diligently toward accomplishment of revision of the fee schedule for workmen's compensation cases.

During the past year the Committee met on two occasions. On May 5, 1959 a meeting was held for the purpose of discussing the final draft of the Proposed Revision of the Average Fee Schedule and the possible manner in which it could best be presented to the Florida Industrial Commission. Revision of the fee schedule was developed through the use of modification of Relative Value Studies and the Blue Shield "A" contract as a basis with conversion factors of 5.0 for surgery and 6.0 for medical services. It was accepted that the fee schedule then currently in effect was outdated and inconsistent in view of rising costs, and further, it was noticeably inadequate due to the limited number of procedures listed.

Through Mr. Harry T. Gray, the Association's legal counsel, a petition requesting revision of the workmen's compensation fee schedule was filed with the Florida Industrial Commission on June 2, 1959. The Committee was then notified that a hearing date before the Industrial Commission was scheduled for Nov. 16, 1959 in the Caldwell Building, Tallahassee. The county medical societies and specialty groups were notified of the scheduled hearing date and were requested to have representation at the hearing.

The Committee met in two sessions on Nov. 15, 1959 (the day prior to the hearing) at the Cherokee Hotel, Tallahassee, for the purpose of considering last minute recommendations received from specialty groups and county medical societies. The two meetings were attended by approximately 20 physicians representing the various specialty groups and county medical societies and from recommendations received, the Committee took the following actions:

A. Eliminated all procedures listed in the proposed revision of the Average Fee Schedule that were not considered compensable under the Workmen's Compensation Law. Of the initial 1,700 items proposed, approximately 825 were deleted.

C. Rejected the recommendations submitted in behalf of the Dade County Radiological Society and the Florida Radiological Society providing for restrictive covenants with regard to diagnostic x-ray services. In lieu, thereof, the proposed fee schedule for diagnostic x-ray service was deleted in its entirety and restored to an "agreed and arranged" basis.

D. Adopted the following additional items to be included as a part of the revised schedule:

Physical Therapy	$ 4.00 (as now allowed)
Hospital Visits	6.00
Blood Transfusions	15.00 (as now allowed)

E. Other actions of the committee included:

(1) Deletion of certain Special Medical Benefits from the proposed schedule because in the opinion of the committee, the procedures were not considered within the purview of the Workmen's Compensation Statute and were therefore non-compensable.

(2) Reaffirmed that dermatology service be included under the regular fee schedule rather than have a separate listing.

(3) Received as information the recommendations of the Florida Psychiatric Society and acknowledged that such recommendations be referred to the Committee on Fee Schedules for further study and consideration.

On the following day, November 16, a hearing was held before the Industrial Commission, at which time Mr. Harry T. Gray, Drs. Ralph W. Jack, F.M.A. President, P. G. Batson Jr., John H. Mitchell, Francis T. Holland and Lloyd J. Netto presented conclusive statements in support of the Association's petition. Chief opponents to the petition were led by Associated Industries of Florida.

In concluding the hearing proceedings Mr. James T. Vocelle, Chairman, commented that consideration would be given to the feasibility of appointing a conference committee consisting of representatives of all interested parties.

On. Dec. 9, 1959, Mr. Vocelle advised that a conference committee was to be appointed and requested the Association to designate six physicians as conferees. In compliance with the request, Dr. Ralph W. Jack appointed the following physicians: Dr. P. G. Batson Jr., Pensacola; Dr. Leroy H. Oetjen, Leesburg; Dr. Charles Larsen Jr., Lakeland; Dr. Francis T. Holland, Tallahassee; Dr. John H. Mitchell, Jacksonville, and Dr. Fred A. Butler, Tallahassee.

Drs. Lloyd J. Netto, West Palm Beach, and Maurice M. Greenfield, Miami, were requested to serve as advisors to the Association's conferees. Designated opponent conferees include five representatives of industry and one representative of labor. Mr. Paul E. Speh, Director, Workmen's Compensation Division, Florida Industrial Commission, was designated to serve as non-voting chairman of the conference committee.

The F.M.A. committee concurs that the meetings and the work of the conference committee should be completed not later than April, 1960 and that the report of the committee be presented to the Industrial Commission.

A supplemental report outlining the activities of the conference committee will be submitted to the House of Delegates at the time of the 1960 Annual Meeting.

Supplement

To summarize the committee's re-negotiation efforts regarding the Workmen's Compensation Fee Schedule and to bring you up to date concerning the Conference Committee's activities, I submit the following:

The Conference Committee held its first meeting on February 7, 1960 and although nothing definite was agreed upon, it was felt that the progress made was a positive indication that industry proposes to submit some form of counter proposition to the proposed fee schedule.

It was of interest to note that the most important and significant point discussed during the conference meeting was that the opponents (industry's representatives, lead by Associated Industries of Florida) repeatedly and emphatically refused to recognize the Association's proposed fee schedule as being indicative of usual or regular fees charged by physicians. Their contention is that the Florida Workmen's Compensation Act essentially provides that physicians' fees shall be limited to such charges as prevail in the same community for similar treatment to injured persons of like standard of living. In further emphasizing this argument, great emphasis was placed upon the expression "persons of like standard of living" with their assertion being that there is an appreciable difference in the economic circumstances of those persons covered under the Workmen's Compensation Act and those classified as "usual private patients" for which physicians charge regular or usual fees for services rendered. In counter to this obviously unfounded allegation, we (medicine's representatives) contend that the vast majority of private patients are "employed persons" and if they were classified, would be considered "persons of like standard of living" as those covered under Workmen's Compensation. (Industrial Commission statistical reports indicate that the average weekly wage of all workers covered under the *Unemployment Compensation Law*, based on employer's quarterly wage reports for the twelve months ended September 30, 1959 was $76.98) At any rate, industry has indicated its desire to conduct a survey of some undisclosed nature, supposedly directed toward gathering employee information regarding fees charged them by family or private physicians for medical services rendered on a private patient basis. Following the February 7 meeting, a supplemental survey soliciting factual data concerning certain medical and surgical procedures was mailed to all component county medical societies. The purpose of this survey was to obtain current information with regard to "usual or regular charges made by physicians" in different areas of the state. This brief survey consisted of two forms. Survey Form #1 requested that the fees charged in the community be listed for the following four items:

Initial Office Visit (without report)
*Initial Office Visit (with report)
*Subsequent Office Visit
*Hospital Visit

*Note: These three items are of highest percentage frequency-wise and account for 43% of total cost as so indicated by study made of approximately 10,000 cases treated under the Workmen's Compensation Program.

Survey Form #2 requested that fees be indicated for thirty-one items which included fractures, hernias and other items common to industrial medicine. The combined survey listed those items of highest frequency cost-wise and which account for approximately 48% of the total cost of cases treated under the program.

To date, completed survey forms have been received from sixteen societies and plans are that another meeting of the Conference Committee is to be held in the near future.

Submitted by:
Charles Larsen Jr., M.D.
Conference Committee Member

Dr. Annis: "The report of the Grievance Committee, presented by Dr. Duncan T. McEwan, Chairman, is approved as printed in the Handbook.

"Mr. President, I move the adoption of this portion of our report."

Motion was seconded and carried.

Annual Report of Grievance Committee

DUNCAN T. McEWAN, *Chairman*

A majority of the grievances submitted to the Florida Medical Association have been referred to the county

medical societies where they have been handled ably. When other matters have been presented for Committee consideration, the Chairman has asked a member of the Committee in that section of the state to investigate the problem and after such investigation, a letter explaining the situation has been written to the claimant. The Committee is not set up to conduct local investigations and can act only in an advisory and reviewing capacity.

The members of the Committee have been most cooperative with the Chairman. No general meeting of the Committee has been called.

Dr. Annis: "The Report of the Committee on Nursing, presented by Dr. Thomas C. Kenaston, Chairman, is approved as printed in the Handbook, and we strongly endorse the resolution on Practical Nursing Education as presented.

"Mr. President, I move the adoption of this portion of the report."

Motion was seconded and carried.

Report of Committee on Nursing

THOMAS C. KENASTON, *Chairman*

Your Committee has maintained liaison with the various nursing groups through the Florida Joint Committee for Improvement of Patient Care. Other organizations represented in that Committee include the Florida Nurses Association, Florida League for Nursing, Florida Public Health Association, and the Florida Hospital Association. The Joint Committee is currently sponsoring a survey of nursing needs and resources in Florida.

Members of your Committee have continued to serve on the State Advisory Committee for Practical Nursing Education. This is advisory to the Department of Education of the State of Florida. The Practical Nurse Training Program is showing healthy growth and the graduate practical nurse is playing an increasingly important role in helping overcome the shortage of nursing personnel both in and out of our hospitals.

Perhaps the most notable development in nursing education has to do with the development of the Associate Degree Program in the Community Junior Colleges.

The W. K. Kellogg Foundation has made a grant to the State of Florida for the improvement of Nursing Education and Nursing Service in Florida with special emphasis on the Community Junior Colleges. This grant, amounting to $370,600.00 over a five year period, will be administered by the Florida State Department of Education and the Florida State Board of Nursing in cooperation with the University of Florida College of Nursing.

As a part of the grant proposal, an advisory committee has been appointed to counsel and advise the State Consultants in the development of this program. Your Chairman, on the recommendation of the President of the Florida Medical Association, has been appointed to this Advisory Committee.

The Associate Degree Program calls for two years preparation in the Community Junior College and an additional year of hospital training. Graduates of the Associate Degree Program will be eligible for examination and certification as Registered Nurses.

In this Committee Report of one year ago, attention was called to the discontinuance of more and more hospital schools of nursing because the increasing requirements for accreditation was making it impossible for the hospitals to meet the requirements imposed upon them. We can at least hope that the Associate Degree Program in the Community Junior Colleges will provide that training the hospital schools of nursing have so ably provided in the past and that the shortage in nursing personnel will be overcome.

Resolution

Practical Nursing Education

WHEREAS, the Florida Medical Association, through two members of its Committee on Nursing, is represented on the Advisory Committee to the State Department of Education on Practical Nursing Education, and

WHEREAS, serious consideration is being given to shortening the length of the clinical day of in-hospital training for those seeking to become Graduate Practical Nurses from its present eight hour day to a six hour day; the reason given for shortening of the clinical day being that the instructors need time to prepare for the next day's instruction, and

WHEREAS, the number of hours of clinical instruction in hospitals would thus be reduced by one quarter of its present number of hours of instruction, and

WHEREAS, it is the considered opinion of the Committee on Nursing that the number of hours of clinical instruction should be increased rather than decreased; therefore,

BE IT RESOLVED, that this House of Delegates go on record as favoring continuation of the eight hour day of clinical instruction which would conform to the hospital day and that the State Department of Education, Division of Vocational and Adult Education, Industrial Education Section, be advised of the sentiments of this House of Delegates in regard thereto.

Presented by
FMA Committee on Nursing

Dr. Annis: "We recommend acceptance of the report of the Committee on Blood, presented by Dr. James N. Patterson, Chairman, as printed in the Handbook.

"Mr. President, I move the adoption of this portion of the report."

Motion was seconded and carried.

Report of Committee on Blood

JAMES N. PATTERSON, *Chairman*

Since the Committee on Blood has had no problems to consider, there has been no formal meeting of this group.

The members of this Committee were polled on the need, if any, for the establishment of commercial blood banks in the state. All members replying to this question agreed that this need does not exist. The inquiry had its origin from a lay individual through the Florida Medical Association; the latter, in turn, referred the matter to the Committee on Blood.

Dr. Annis: "We recommend approval of the Report of the Committee on Medical Economics, presented by Dr. Floyd K. Hurt, Chairman, including the insurance program and the Investment Trust Plan, as outlined. We recommend to all county medical societies that they repeatedly inform their members of the availability and the benefits to be derived by participation in these programs.

"Mr. President, I move the adoption of this portion of the report."

Motion was seconded and carried.

Report of Committee on Medical Economics

FLOYD K. HURT, *Chairman*

Your Committee continued its interest in economic matters of concern to the medical profession. The three most important matters to which attention was directed were:

1. Continued encouragement of physician participation in the Association sponsored insurance program.
2. Efforts to obtain a professional liability insurance plan on a group basis.
3. Development of an investment trust plan designed exclusively to meet the needs of physicians.

Insurance Program.

The Association's insurance program is well established and has proven to be of invaluable benefit to a number of members of the Association. Improvements made during the past year are as follows:

1. The definition of dependent under the Catastrophe Hospital-Nurse Protection Policy has been broadened to cover unmarried children in a student category to age 23.
2. Office Overhead Expense Insurance has been made available to the membership through the Continental Casualty Company.
3. A program of Accidental Death or Dismemberment Insurance has been offered the members. This program is underwritten by the Columbia Casualty Company.
4. A special Travel Accident Insurance policy was continued to cover FMA members while traveling on official business of the Association.

As a result of the favorable loss experience under the Disability Income Protection plan, the following beneficial changes were made:

1. Without additional premium charge, the insured member will receive 50% additional weekly indemnity while hospitalized, up to a maximum of 70 days. This will apply retroactive to claims since August 1, 1959.
2. The present maximum weekly indemnity of $100 is increased to $150 for members under age 55. This change is, of course, optional and is available only on a statement of satisfactory health.
3. The underwriting limits of the Continental Casualty Company have been correspondingly increased as follows:

	Former Limits	New Limits
All Companies	$1,900	$1,900
Continental Casualty Company	1,100	1,500
Association Group Division	800	1,300

These changes were filed with the Insurance Commissioner of Florida and after approval, a general mailing was sent out to the entire FMA membership advising them of these increased benefits.

With respect to the disability insurance, the present participation is considerably short of that needed to offer insurance to all members, regardless of medical history. The eligible members under age 60 total 2,300, and those under 70 total 2,550. A total of 900 applications have been received, or about 30% of the eligibles. At this time it appears that a re-opened charter enrollment period holds no possibility of qualifying the program prior to the spring of 1961.

The following data summarize the insurance program since it was established August 1, 1956.

Type of Insurance	Policies in Force	% Membership Covered
Disability Income	631	17%
Catastrophe Hospitalization	432	12%
Office Overhead Expense	119	3%
Accidental Death or Dismemberment	66	2%

Although the insurance program indicates a steady growth, it is obvious that the membership has not purchased these excellent programs in numbers great enough to realize the benefits achieved by having true groups. New members, and old members too, are encouraged to participate in these insurance programs which are as good as any available and will become better with the bargaining power gained by having true group participation.

Professional Liability Insurance.

Several attempts have been made in an effort to obtain on a group basis a plan for professional liability insurance; however, the several companies with which this most important matter was discussed could not at the present time offer an acceptable plan. Negotiations in this regard are to continue.

FMA Investment Trust Plan.

The Committee's recommendations as adopted by the House of Delegates at the time of the 1959 Annual Meeting regarding development of an investment plan for Association members has received considerable attention. The Declaration of Plan and Trust Agreement establishing the FMA Investment Trust as prepared by the Association's attorneys, the Florida National Bank of Jacksonville, and your Committee was approved and executed by the Board of Governors on January 16, 1960. The Board has designated the FMA Investment Trust Committee and the Restricted Retirement Trust was made available to the membership as of April 1, 1960. A brochure describing the plan with application for participation has been mailed to each member of the Association. Each member is encouraged to contact the Investment Trust Committee regarding details of the plan.

Dr. Annis: "Your Reference Committee recommends acceptance of the Report of the Committee on Commercial Health Insurance, presented by Dr. Duncan T. McEwan, Chairman, with reference to insurance examination fees and standardized claim forms. It has been recommended to your Reference Committee, and approved, that an information release form, to be signed by the patient, be imprinted on or attached to all insurance forms.

"Mr. President, I move the adoption of this portion of the report as amended."

Motion was seconded and carried.

Report of Committee on Commercial Health Insurance

DUNCAN T. McEWAN, *Chairman*

The 1959 meeting of the House of Delegates of the Florida Medical Association referred to our committee, for action, three resolutions. Similar resolutions from the Broward County Medical Association and from the Lecn-Gadsden-Liberty-Wakulla-Jefferson County Medical Society dealt with an increase in fees for life insurance physical examinations. The third resolution from Broward County dealt with the adoption of standard simplified claim forms by the Florida Medical Association.

STANDARDIZED CLAIM FORMS: Your committee has worked with the Health Insurance Council to prepare simplified claim forms. This is submitted to you, subject to the committee's approval of the final forms. It is recommended that HIC Forms Nos. UND-1 and COMB-1 and the attached assignment form be made accessible to the members of the Florida Medical Associa-

tion; also, that all insurance companies operating in the state be informed of our approval of these forms and be urged to adopt such standardized forms. If such adoption has not been carried out before the next meeting of the House of Delegates, it is recommended that further action be taken at that time.

INSURANCE EXAMINATION FEES: There is no organization or committee which can act for the insurance industry as a unit. The raising of fees must be an individual act by each company.

Your resolution was presented unofficially to the executive council of an association of medical directors of life insurance companies. Although they could take no action for the insurance industry as a whole, they were most understanding of our viewpoint. This has resulted in the adoption of a $10 fee by many companies. Those that have been brought to my attention are Equitable Life Assurance Society, Prudential Insurance Company, Homeowners Life Insurance Company, National Standard Life Insurance Company, Liberty Life Insurance Company, Lincoln National Life Insurance Company, and probably many others. In the past other companies have followed rapidly this lead so in our opinion it will become universal in a short time.

VISITS WITH COUNTY MEDICAL SOCIETIES: In cooperation with Dr. Paul Reinartz of the Health Insurance Council a majority of county medical societies has been visited in the past year. The discussions at these meetings have brought out the viewpoints of the doctors of the state and of the insurance companies, have resulted in a better understanding and stressed the necessity of cooperation between us if private enterprise is to survive the threat of government-controlled medicine and insurance.

ASSIGNMENT OF BENEFITS

I hereby authorize.....to pay directly
Name of Company
to.....the benefits otherwise pay-
Print Name of Physician
able to me under.....for his surgical
Policy or Certificate No.
and/or medical services as described in the attached statement, but not to exceed the charge for these services. I understand that I am financially responsible for those charges not paid by my insurance.
Date..... Signed.....
Insured

Dr. Annis: "The Reference Committee approves in principle the admittedly hastily-written resolution to encourage the education of employers in the utilization of the talents of our aged and to oppose compulsory retirement on the basis of age alone, which was submitted by Broward County Medical Association. We recommend that this resolution not be printed in The Journal in its present form, but that it be referred to the Florida Medical Association's delegates to the American Medical Association, so that its principles may be expressed in proper form.

"Mr. President, I move the adoption of this portion of the report as amended."

Motion was seconded and carried.

Dr. Annis: "The resolution regarding the term 'Cost of Medical Care', presented by the Dade County Medical Association is approved.

"Mr. President, I move the adoption of this portion of the report."

Motion was seconded and carried.

Resolution

Term "Cost of Medical Care"

WHEREAS, it is apparent that the term "the cost of medical care" has become widely used by government agencies, publications and others, and

WHEREAS, the term has been employed to include not only physicians' fees but the entire scope of health-related costs such as drugs, dental, nursing and hospital care, and

WHEREAS, the greatest health cost today is for "labor" or for personnel, and

WHEREAS, physicians' fees are only a part of the overall health-related costs; therefore be it

RESOLVED, that the Florida Medical Association go on record as encouraging the term "physicians' fees" in contrast to the overall medical care expense; and be it further

RESOLVED, that the Florida Medical Association's delegates to the American Medical Association be instructed to introduce a similar resolution before that body's House of Delegates; and be it further

RESOLVED, that copies of this resolution be forwarded to the American Medical Association and to appropriate agencies of the federal government.

Presented by
Dade County Medical Association

Dr. Annis: "Your Reference Committee reviewed the report of the Chairman of the Committee on Medical Education and Hospitals, Dr. Thomas O. Otto. The first recommendation of this report is approved as written.

"Mr. President, I move the adoption of this portion of the report."

Motion was seconded and carried.

1. *That a law be drawn up and enacted at the next term of the Florida Legislature, requiring that 100 per cent of patients be available for teaching purposes at all schools teaching medicine and receiving a subsidy from the State of Florida.*

Dr. Annis: "Pertaining to the second recommendation of the report, which recommends that a law be drafted requiring at least two-thirds of all patients admitted to be indigent, it was the feeling of your Reference Committee that classification of indigency is impossible, because of true indigency, medical indigency, relative or marginal indigency; as well as those who come under allied health services such as Crippled Children's Commission, Vocational Rehabilitation Service, Cancer Program, Council for the Blind, National Foundation, and many others. In view of the activities on the part of medicine through Blue Cross-Blue Shield, the Associated Health Industries of Florida, and other insurance companies, we are looking forward to the day when all people, except those on direct welfare, will be

covered by one form or another of private insurance, making even more difficult the determination of indigency.

"The Metropolitan Commission in Dade County has established by authority of its Home Rule Charter the percentage of charity, part-pay, and private patients in the Teaching Hospital. The Committee feels that the University Hospital in Gainesville is young in experience and there is insufficient information available at the present time for any specific recommendation concerning the desirable percentages of private, part-pay and charity patients.

"Mr. President, I move the adoption of this portion of the report as amended."

Motion was seconded and carried.

Dr. Annis: "On the third recommendation, the Committee wishes to point out that it has been called to our attention that there are many people, both within and without the state, who do not realize that we have a University of Florida College of Medicine. It is our recommendation that the Board of Governors appoint representatives of this Association to discuss this subject with representatives of the University, with the intent of placing proper emphasis on the *University of Florida College of Medicine* at Gainesville. We have prepared a slide which is a photostat of an ordinary sheet of their stationery. At the top it says 'The J. Hillis Miller Health Center, University of Florida, Gainesville', and over in the left hand corner in type similar in size to that used for the telephone number, it says 'College of Medicine, Department of Pediatrics.' I also understand that the College of Medicine is not listed as such in the Gainesville telephone directory but only under The J. Hillis Miller Health Center.

"Mr. President, I move the adoption of this portion of the report as amended."

Motion was seconded and carried.

Dr. Annis: "Your Reference Committee agrees with the philosophy expressed in recommendation No. 4. We recommend to the Board of Governors that they instruct our delegates to the American Medical Association to investigate and study the question of the increasing infiltration of non-medical personnel in the field of medical education.

"Mr. President, I move the adoption of this portion of the report as amended."

Motion was seconded and carried.

4. *Physicians should not relinquish their heritage by surrendering the practice of medicine to others, and to the Federal Government. Each state should maintain the control of its institutions; and the staffing of these institutions, and the expenditures necessary for same, regardless of the source from which the wealth comes to maintain them. This should be done regardless of the amount necessary to be appropriated to meet this need.*

Dr. Annis: "On recommendation No. 5, we agree in principle with the idea of well equipped regional hospitals, staffed by the physicians of the area, rather than numerous smaller hospitals.

"Mr. President, I move the adoption of this portion of the report as amended."

Motion was seconded and carried.

Dr. Annis: "The report of the Chairman of the Committee on Medical Education and Hospitals was provocative of much discussion and deserving of much consideration, the results of which we have attempted to report back to you with the recommendation that the original report not be printed in The Journal.

"Mr. President, I move the adoption of this portion of the report."

Motion was seconded and carried.

Dr. Annis: "Your Reference Committee was asked to consider a previous report approved by the House of Delegates regarding medical education, and in addition to our previous recommendations, your Reference Committee feels very deeply concerning the University Hospital situation in the Gainesville district in reference to the non-availability of this facility to the qualified physicians and their private patients in the surrounding area. It is felt that immediate steps should be taken for study concerning this situation. To correct this urgent and serious problem which now prevails, we recommend that the Board of Governors instruct the Council on Medical Education and Hospitals to institute an immediate study and that their findings and recommendations be brought back to the Board of Governors for review and prompt action.

"Mr. President, I move the adoption of this portion of the report."

Motion was seconded and carried.

Dr. Annis: "Mr. President, I move the adoption of the report of Reference Committee No. 2 as a whole."

Motion was seconded and carried.

Report of Reference Committee No. 3

Finance and Administration

Dr. Edward Jelks: "Mr. President and Members of the House of Delegates: Your Reference Committee No. 3, the composition of which is printed in the Handbook, gave careful consideration to items referred to it and makes the following report:

"The Address of our President, Dr. Ralph W. Jack: This fine and moving address is approved and his sentiments are strongly endorsed by your Committee.

"Mr. President, I move the adoption of this portion of the report."

Motion was seconded and carried.

(Complete text of the Presidential Address will be found on page 1485)

Dr. Jelks: "The Report of the Board of Governors, presented by Dr. Jack, is approved as printed in the Handbook.

"Mr. President, I move the adoption of this portion of the report."

Motion was seconded and carried.

Report of Board of Governors

RALPH W. JACK, *Chairman*

During the administrative year and prior to the printing of this report, five meetings of the Board of Governors have been held. They were at Bal Harbour on May 6, 1959, Jacksonville on June 28, 1959, September 12, 1959, January 16, 1960 and a called meeting February 7, 1960. If another meeting is held before the annual meeting, it will be covered in a supplement to this report and will be presented to the first meeting of the House of Delegates on April 8, 1960.

I wish to express my deep appreciation to all the members of the Board who have worked diligently and attended the meetings at great sacrifice of time and convenience to assist in conducting the business of your Association. I am sure that each member of the Association will join me in thanking them for their generous contributions.

Significant Changes

CHARTER AND BY-LAWS—The Charter and By-Laws, approved by the House of Delegates in May 1959, were ratified by the required three-fourths of the component county medical societies with one county society dissenting. The amended Charter has been filed with the Secretary of State of Florida and is now in effect. The By-Laws have been in effect since the 30th county society ratified them. Every provision of the new By-Laws, where feasible, has been implemented. The new council and committee system and positions elected by the House of Delegates will not be implemented until April 11 at the beginning of the Association's new year, as it was not feasible to disrupt and reorganize the committees before the end of their year's work.

AMENDMENTS TO BY-LAWS—The Board of Governors carefully reviewed the suggestions made by the component county medical societies and individual physicians and compiled the following amendments to the By-Laws, and recommend their adoption:

1. Chapter IV, Section 3, CALLED MEETING, add the following sentence at the end of this paragraph: "The purpose of the called meeting and its agenda shall be stated in the notice calling the meeting."
2. Chapter IV, Section 6, DETERMINATION OF DELEGATES, Paragraph 1, in lines 3 and 5, the word "twenty" be changed to "twenty-five."
3. Chapter IV, Section 6, DETERMINATION OF DELEGATES, Paragraph 2, line 3, after the word "Vice Speaker" add "Members of the Council on Specialty Medicine."
4. Chapter IV, Section 7, DELEGATES TO HOUSE OF DELEGATES OF AMERICAN MEDICAL ASSOCIATION, add the following as Paragraph 3:

   "Immediately following the Florida Medical Association's Annual Meeting, the AMA Delegates shall meet and select a chairman for the coming year, among whose responsibilities shall be to have present at each meeting of the Board of Governors a member of the delegation."
5. Chapter IX, Section 1, Paragraph 3, THE JUDICIAL COUNCIL, delete "Necrology" in line 3, and insert "Archives" thereby changing the name of this committee.
6. Chapter IX, Section 2, COMPOSITION, SELECTION AND TENURE OF COMMITTEES, Paragraph 5, Medical Schools, on line 9 delete "A" and add "B" and insert in parenthesis in the same line after "C" "not having an approved medical school within its boundaries."
7. Chapter IX, Section 2, Paragraph 7, MEMBERSHIP AND DISCIPLINE, add the following at the end of the paragraph: "and any additional nominations made from the floor."
8. Chapter IX, Section 2, add paragraph 14, "COMMITTEE ON EMERGENCY MEDICAL SERVICE shall also serve as the Advisory Committee to Selective Service."
9. Chapter IX, Section 3, DUTIES AND FUNCTIONS, subsection 1, paragraph 2 to be deleted.
10. Chapter X, Section 2, DUES 1. Annual Dues, in line 4 following the words "for associate members" the remainder of the sentence be changed to read:

    "except that medical interns and full time physicians in a residency approved by the local county medical society shall not be required to pay any annual dues."
11. Chapter XI, Section 1, CHARTERS, at the end of paragraph 2, add "Policies adopted by the Florida Medical Association's House of Delegates shall be binding upon the component county medical societies and their members."

MEDICAL DISTRICTS—In compliance with Chapter 7, Section 2, Paragraph 8, which reads as follows: "The Board of Governors shall divide the state into not less than four Medical Districts based insofar as feasible on physician population, and define their boundaries,"

the Board of Governors divided the Association into four medical districts as follows:

A—*North Medical*—Alachua (Bradford, Gilchrist, Union), Bay, Columbia (Baker), Duval (Clay), Escambia, Franklin-Gulf, Jackson-Calhoun, Leon-Gadsden-Liberty-Wakulla-Jefferson, Madison, Marion (Levy), Nassau, Putnam, St. Johns, Suwannee-Hamilton-Lafayette, Taylor (Dixie), Walton-Okaloosa-Santa Rosa, Washington-Holmes (831 members).

B—*West Medical*—Collier, Charlotte, DeSoto-Hardee-Glades, Highlands, Hillsborough, Lake (Sumter), Lee-Hendry, Manatee, Pasco-Hernando-Citrus, Pinellas, Polk and Sarasota (956 members).

C—*East Medical*—Brevard, Broward, Indian River, Orange (Osceola), Palm Beach, St. Lucie-Okeechobee-Martin, Seminole and Volusia (Flagler) (932 members)

D—*South Medical*—Dade and Monroe (985 members)

ALLIED PROFESSIONS AND VOCATIONS AND SPECIALTY GROUPS—In compliance with Chapter 8, Section 3, Paragraphs 1, 9 and 10, the Board of Governors officially recognized the following allied professions and vocations: Dentistry, Law, Medical Secretaries and Assistants, Medical Technicians, Nursing, Pharmacy, Physical Therapy, Veterinary Medicine, and X-Ray Technicians; adopted criteria for the evaluation of specialty groups to be officially recognized and; adopted criteria to be used in officially recognizing voluntary health agencies.

RESEARCH—The Board activated the Committee on Research and this committee shall also be utilized by the Florida Medical Foundation in awarding research grants.

COMMITTEE ON MEMBERSHIP AND DISCIPLINE—In compliance with Chapter 9, Section 2, Paragraph 7, the Board selected the following nominees to be voted upon by the House of Delegates to select two physicians from each Congressional District to serve on the Committee on Membership and Discipline, with the provision that additional nominations may be made from the floor of the House of Delegates:

District 1	William C. Blake	'61
	C. Frank Chunn	
	Francis H. Langley	'64
	N. Worth Gable	
District 2	Joseph J. Lowenthal	'62
	Ashbel C. Williams	
	Raymond H. King	'63
	Karl B. Hanson	
District 3	George H. Garmany	'63
	Jabe A. Breland	
	Sidney G. Kennedy	'62
	William D. Cawthon	
District 4	Nelson Zivitz	'64
	S. Charles Werblow	
	Walter C. Jones	'61
	Frazier J. Payton	
District 5	Duncan T. McEwan	'61
	Chas. J. Collins	
	Herbert E. White	'64
	C. Robert DeArmas	
District 6	Frederick K. Herpel	'62
	H. Quillian Jones	
	Miles J. Bielek	'63
	Russell B. Carson	
District 7	Gordon H. McSwain	'63
	Edgar Watson	
	John M. Butcher	'62
	Millard P. White	
District 8	Thomas H. Bates	'64
	J. Maxey Dell Jr.	
	William C. Thomas Sr.	'61
	John E. Maines Jr.	

APPOINTMENTS—Due to the major reorganization under the new By-Laws, your President-Elect, Dr. Leo M. Wachtel, presented his appointments for the Board, Councils and Committees to the Board of Governors which approved them. These appointments will appear in the May issue of The Journal.

SUBCOMMITTEES—The Board established a subcommittee to promote the Florida Medical Foundation, a subcommittee on Inter-American relations, a subcommittee on hypnosis and a subcommittee on General Practitioner Award.

Major Activities

ANNUAL MEETING—The Board approved the schedule and program for the annual meeting, submitted by Thad Moseley, M.D., Chairman, Scientific Work Committee. This is a departure in format from previous years. The meeting will begin on Friday and end on Monday, providing more utilization of the weekend, and the scientific program is being presented in cooperation with the various specialty groups. The Board approved sharing fifty per cent of the expense for specialty society speakers being utilized on the scientific program of the Association.

SITES FOR 1961, 1962 and 1963 ANNUAL MEETINGS—It is the recommendation of the Board of Governors that Miami Beach be designated as the site for the 1961 and 1962 annual meetings and that the meetings be held at the Americana Hotel on May 26-29, 1961 and April 27-30, 1962, and that the Americana be requested to hold the dates of May 16-20, 1963 in reserve for the Association.

BUDGET—The Board reviewed a financial statement and analysis for the Association for the past ten years and specifically a financial statement and analysis for the year ending December 31, 1959. A proposed budget prepared by the Secretary-Treasurer and Executive Director was approved, in the amount of $219,800 (including reserve of $10,500) for the calendar year of 1960. This budget is based upon an estimated income for the same period of $226,000. A complete audited statement will appear in the Secretary-Treasurer and Executive Director's report.

The Board approved rendering administrative assistance by the Association's executive office to specialty groups approved by the Board of Governors on a one year trial basis beginning January 1, 1960.

FMA INVESTMENT TRUST—The Board authorized the execution of a Trust Agreement and Declaration of Plan with the Florida National Bank of Jacksonville to implement the FMA Investment Trust as approved by the House of Delegates last year and recommended by the Committee on Medical Economics. The FMA Investment Trust Committee was appointed. This Trust Committee will also be utilized by the Association in advising the Association on investment of its funds, if and when available.

INDEMNIFYING REPRESENTATIVES—The Board adopted a resolution on indemnifying representatives of the Association if sued and judgment awarded against them while acting in an official capacity on behalf of the Association.

BLUE SHIELD COVERAGE, FEDERAL EMPLOYEES PROGRAM—The Board, in an emergency called meeting on February 7, approved participation by Blue Shield of Florida in the national health insurance program for Federal Civil Service Employees, with the $4,000 and $6,000 income limits for service benefits as per the fee schedule which was originally proposed by the FMA Committee of Seventeen, which has a conversion factor of $5.00 for the $6,000 limit and 4/6th of this schedule for the $4,000 contract.

The Board was of the opinion that inasmuch as this had been presented to it as an emergency measure by

Blue Shield in which a decision was required immediately, it adopted this resolution under the authority granted it by the House of Delegates in May 1958 subject to the ratification of the members of the House of Delegates on a mail vote, signifying whether the delegates approve the action of the Board of Governors or desire a meeting of the House of Delegates on February 21, to further explore the situation. This action taken by the Board was only after thorough consideration of the problem and affirmative advice from the Committee of Seventeen.

RELATIVE VALUE STUDIES—In compliance with Chapter IX, Section 3, Paragraph 3, of the By-Laws which reads in part: "The Committee on Fee Schedules shall be responsible for the study, development or modification of all fee schedules accepted or endorsed by the Association," your Board recommends that the House of Delegates direct official recognition and acceptance of the use and principle of Relative Value Studies in furthering the work of the Committee on Fee Schedules.

INDIGENT CARE—Your Board recommends that the House of Delegates, in an effort to further reaffirm the Principles of Medical Ethics, adopt the following statement of policy which shall be binding upon all members of the Association:

> *Statement of Policy*—Physicians' services shall be made available without charge to those patients who are recognized and declared to be indigent as so determined through application of criteria as approved by the respective component county medical societies of the Florida Medical Association.

CONFERENCE COMMITTEE, WORKMEN'S COMPENSATION—The Board approved the appointments made by the President of six physicians to the Conference Committee established by the Chairman of the Florida Industrial Commission to further study the proposed revision of the fee schedule for the workmen's compensation cases.

OSTEOPATHY—Your Board recommends that the University of Florida College of Medicine be advised that its department would be unwise to allow osteopathic functions. As there is no osteopathic school at the University, it was felt there would be no medical scientific value to such meetings and its use for osteopathic functions is protested on behalf of the doctors of medicine of Florida. Also the professors participating in such programs would be violating medical ethics.

GENERAL PRACTITIONER AWARD—The Board authorized the establishment of a subcommittee of not less than three or more than five members, to recommend a general practitioner of the year. The physician recommended would be the nominee from Florida to the American Medical Association for consideration as the national general practitioner of the year. The committee would be empowered to make nominations itself and also to accept nominations from the county medical societies and from the Florida Academy of General Practice.

RADIOLOGY—The Board considered a request from the Florida Radiological Society for the active support of the Association in preventing further violation of the laws of Florida and policies of the Association by Blue Cross of Florida in providing x-ray diagnostic benefits. The Board recommended that the problem be referred to a committee composed of representatives of the Florida Medical Association, Florida Radiological Society, Blue Shield and Blue Cross of Florida, in consultation with the Florida Hospital Association.

PROGRAM DOCUMENT—The Board, as was done the previous year, adopted a program document for the Association encompassing the recommendations of the House of Delegates, major areas of work to be conducted by committees, and other projects to be accomplished during the year. The Board is pleased to report that most of the programs have been completed, implemented or are under study.

Assistance to Committees

The Board, during the year, had the opportunity and privilege to work closely with many committees of the Association. The chairmen of numerous committees appeared before the Board to present programs, reports and make recommendations and request Board approval of activities. These activities and recommendations of the committees appear in their respective reports.

Dr. Jelks: "The Annual Joint Report of the Secretary-Treasurer and Executive Director is approved as presented.

"Mr. President, I move the adoption of this portion of the report."

Motion was seconded and carried.

(The Annual Joint Report appears on page 1546 of this issue.)

Dr. Jelks: "The Report of the Necrology Committee, and supplement, presented by Dr. Clifford C. Snyder, Chairman, is approved with the recommendation that the name of the committee be changed to 'Committee on Archives' as presented in the Report of the Board of Governors.

"Mr. President, I move the adoption of this portion of the report."

Motion was seconded and carried.

Dr. Jack: "We will pause for a moment and at this time I will ask Dr. Snyder to come forward and read the names of this year's deceased members."

Dr. Snyder read the list of members who have died this past year. The House rose for a moment of silent prayer.

Dr. Jack: "I don't know if all of you realize but this list contained the names of two of our past presidents, Dr. William E. Ross and Dr. Julius C. Davis."

Report of Committee on Necrology

CLIFFORD C. SNYDER, *Chairman*

In compliance with suggestions by President Jack that this Committee be taken from the pile of dead wood and rekindled into a strong functioning organ, the chairman immediately took steps by making a trip to Jacksonville, writing a number of letters and making a few telephone calls. Mrs. Zoe Pack received me kindly and with her exceptional cooperation we made plans for a progressive year by compiling data. A form letter was sent to the members of the Committee in regards to a proposed meeting of the group in Jacksonville. The response from the letter presented problems of travel, time consumption and previous commitments; so future business was undertaken through channels of letters. In summation the results of this correspondence were:

(1) That the committee's name, Necrology Committee, is an incorrect title for such a committee, that it be deleted and a new name proposed. The committee's consensus was that though we deal in dead matter, our function is to write a memoriam of the deceased member so that other members of the As-

sociation may read of his accomplishments in life. Usually the deceased member's kin and dear ones save this memoriam as a keepsake. They are proud that our Association thought enough of this member to write and publish such a memoriam.

(2) Names that have been submitted for this committee are:

Remembrance Committee, Memorial Committee, In Memoriam Committee, Commemorative Committee, Biographical Committee or Reminiscence Committee.

(3) It occurred to the Committee that when a member dies, the secretary of that local county medical group is written and asked to personally, or by affiliate, approach the wife or family for a short resumé of the member's life history. This interview takes place immediately following the death of the member in order that it may be included in the next issue of The Journal. At this most inopportune time the feeling of sorrow is at an extreme, the family has not recovered from the shock, and the interviewer is reluctant in his approach. The committee proposes a revision in this curriculum. The time and manner of interview should be changed. A list of Association members who are of the age of 60 years and over are in our hands per the cooperation of Mrs. Zoe Pack. These members could be interviewed and a short history of their lives could be placed in the Archives in Jacksonville. The member would feel proud to know that his Association thinks enough of him to do such a thing. The time would be opportune and not during the height of grievance following death. Many contacts could be made at conventions by the committee. This would attract more of the older and some of the "dead wood" to the conventions. It would also give some impetus to the members of the committee, who at the present have very little function on the committee. The committee membership could be enlarged; the burden would be lighter. The present chairman of this Committee is extremely interested in such a program and would spend a great deal of time developing it.

Since June, 1959 there have been eighteen deaths involving members of the Florida Medical Association. These have been acted upon and the usual course of procedure achieved. The names, dates and county society membership are attached herewith.

The committee wishes to express our thanks to Mrs. Zoe Pack, Director of the Administrative Department of the Florida Medical Association, for her untiring desire to help us and the cooperation she afforded to making our committee function properly.

June, 1959
Howard K. Edwards, M.D. ..... Dade
Byrne E. Taylor, M.D. ..... Orange

July, 1959
Lester W. Cunningham, M.D. ..... Duval
Americo J. Ferlita, M.D. ..... Hillsborough

August, 1959
Anna A. Darrow, M.D. ..... Broward
Marvin H. Smith, M.D. ..... Dade
Estella G. Norman, M.D. ..... Dade
Stewart L. Jeffrey, M.D. ..... Dade
Duncan M. Draughn, M.D. ..... DeSoto-Hardee-Glades

September, 1959
John E. Gottsch, M.D. ..... Hillsborough
Benj. F. Barnes, M.D. ..... Leon-Gadsden et al
Arthur R. Beyer, M.D. ..... Hillsborough

October, 1959
W. Wellington George, M.D. ..... Palm Beach
David F. Harwell, M.D. ..... Duval

November, 1959
Frank E. Irons, M.D. ..... Polk
Cleveland C. Fuqua, M.D. ..... Nassau
Isaac W. Chandler, M.D. ..... DeSoto-Hardee-Glades

January, 1960
Eaton G. Lindner, M.D. ..... Marion

Supplement

In addition to those reported in the Handbook, the Association has also lost the following members through death:

April, 1959
Clarence Bernstein, M.D. ..... Orange
Francis J. McNally, M.D. ..... Broward
Rosa L. Sullivay, M.D. ..... Escambia

May, 1959
Paul Kass, M.D. ..... Dade
William E. Ross, M.D. ..... Duval

June, 1959
Leonard G. Rowntree, M.D. ..... Dade

September, 1959
Hugh H. Barfield, M.D. ..... Marion

October, 1959
Morris J. Alexander, M.D. ..... Charlotte
John A. Coleman, M.D. ..... Hillsborough

November, 1959
Frederic H. Wood, M.D. ..... Manatee

December, 1959
Robert H. Cleveland, M.D. ..... Duval

January, 1960
Harry Z. Silsby, M.D. ..... Seminole

February, 1960
Julius C. Davis, M.D. ..... Leon-Gadsden, et al
James I. Thorne, M.D. ..... Dade

April, 1960
A. Louis Girardin Jr., M.D. ..... Lee-Hendry

Dr. Jelks: "The report of Advisory to Woman's Auxiliary Committee, presented by Dr. Sidney G. Kennedy Jr., Chairman, is approved as printed in the Handbook.

"Mr. President, I move the adoption of this portion of the report."

Motion was seconded and carried.

Report of Committee on Advisory to Woman's Auxiliary

SIDNEY G. KENNEDY JR., *Chairman*

Members of the Advisory Committee were privileged to meet with the Board of Directors and committee members of the Woman's Auxiliary to the Florida Medical Association at the Post-Convention Board of Directors Meeting in Bal Harbour May 5, 1959, at which time we were presented copies of the Auxiliary convention reports. We were greatly impressed by the tremendous amount of work done by members of the various Auxiliaries, as represented by these reports, which, we are sure, has resulted in much good will and betterment of public relations over the state.

A second meeting of the Committee was held with the State Auxiliary Board at the Fall Board Meeting in Tallahassee, Oct. 15, 1959, at which time the High School Essay Contest on the subject "The Advantages of the

American Free Enterprise System" sponsored by the Association of American Physicians and Surgeons, and approved by the 1959 F.M.A. House of Delegates, was presented to the Board. It was adopted as an Auxiliary project for 1960. We were grateful for helpful suggestions from President Jack who was able to be with us on both of the above mentioned occasions.

We wish to commend the Auxiliary on the fine work done in community service during the past year under the enthusiastic and efficient leadership of Mrs. Wendell J. Newcomb. Mrs. Newcomb reports the creation of one new Auxiliary during the year—The Woman's Auxiliary to the Highlands County Medical Society.

The Committee recommends that one or more programs be presented annually to the State Woman's Auxiliary either during the Annual Convention or at the Fall Board Meeting, in the form of a panel of F.M.A. Officers and Key Committee Chairmen, for the purpose of better acquainting its members with current problems of the Association and the medical profession.

Dr. Jelks: "The report of Councilor Districts and Council, by Burns A. Dobbins Jr., Chairman, is approved as printed in the Handbook. The supplemental report, which recommends that a charter be granted to Clay County Medical Society, is also approved.

"Mr. President, I move the adoption of this portion of the report."

Motion was seconded and carried.

Report of Council

BURNS A. DOBBINS JR., *Chairman*

No meetings of the Council have been held up to the time of this report, Feb. 1, 1960.

Under the guidance of Councilor J. Maxey Dell Jr., the application for charter of a new county medical society is under consideration.

An appeal from a ruling of the Dade County Medical Association's Board of Censors has been made to the Council and is under consideration at this time.

Supplement

The Council has considered the request and desire of those Florida licensed physicians practicing in Clay County for a separate component county medical society to be known as the Clay County Medical Society.

It is our recommendation that this request be granted.

Dr. Jelks: "The report of the Advisory to Selective Service Committee, presented by Dr. Corren P. Youmans, Chairman, is approved as printed in the Handbook.

"Mr. President, I move the adoption of this portion of the report."

Motion was seconded and carried.

Report of Committee on Advisory to Selective Service for Physicians and Allied Specialists

CORREN P. YOUMANS, *Chairman*

Since becoming Chairman of this Committee, there have been only two cases referred to it for checking.

This information was secured and sent to Chief, Manpower Division, Selective Service System, State Headquarters, St. Augustine, Florida.

Dr. Jelks: "The report of the Civil Defense and Disaster Committee, presented by Dr. Corren P. Youmans, Chairman, is approved as printed in the Handbook.

"Mr. President, I move the adoption of this portion of the report."

Motion was seconded and carried.

Report of Committee on Civil Defense and Disaster

CORREN P. YOUMANS, *Chairman*

During the past year interest has increased in civil defense and possible disaster. The public is becoming aware that a definite, well-planned course of procedure is necessary in case of a major disaster and that prearranged shelters, plans for evacuation, and plans for emergency hospitalization, in time when things are quiet, be set up and worked out in a definite outline of procedure. Also, that instructions should be given in first aid and in treatment of casualties caused by thermo-nuclear exposure.

The Civil Defense and Disaster Organization of the State of Florida has made great strides in preparing a workable plan to be used in case of a major disaster. It has divided the State of Florida into six groups and is well manned by the State officials and employees.

However, for the Florida Medical Association to do its part in the effective care of casualties, in case of disaster, it is necessary that the emergency hospitals be well staffed with doctors, and it is to this end that the Committee is striving to put into effect a listing and organization of the medical personnel in the areas of these different groups—to man the hospitals as set up by the Civil Defense and Disaster organization.

During the next year, it is hoped that each President of the County Medical Societies and the Chairmen of the County Civil Defense and Disaster Committees can be contacted and that they will, in turn, assist in securing volunteers from the medical profession to man the hospitals that are now available, and the emergency hospitals that have been secured and other temporary hospitals that may be formed. For an effective organization we trust that this will soon be in effect.

The Medical Disaster Committee of the Dade County Medical Association is to be commended on its excellent work done on the night of June 17, 1959, when a tornado hit and did severe damage in the Miami area. Dr. Julian Rickles is chairman of this committee.

Dr. Jelks: "The report of the Advisory Committee to Blue Shield by Dr. Robert E. Zellner, Chairman, is approved as printed in the Handbook. The supplemental report is approved with the deletion of the last paragraph. Your Committee heard considerable discussion regarding the old age program and the recent action taken by the Blue Shield Board of Directors and recommends that the contract presently available for those over 65 be more widely advertised and that further consideration be given to making coverage more generally available to people in this age group.

"Mr. President, I move the adoption of this portion of the report."

Motion was seconded and carried.

Report of Advisory Committee to Blue Shield

ROBERT E. ZELLNER, *Chairman*

This Committee is charged with the dual responsibility of advising Blue Shield authorities of the desires and needs of the doctors of Florida with regard to prepayment of medical care and of bringing to the attention of members of the Association problems of Blue Shield in which they are concerned. This year the Committee has been active in both phases of this responsibility.

Old Age Contract

At the last meeting of the House of Delegates a resolution introduced by the Broward County Delegation asking that "Florida Blue Shield be requested to study the feasibility of providing at reduced premiums medical and surgical coverage for those citizens over 65 with an income for a couple of $3000.00, and for a single individual of $2000.00, and that the physicians of Florida agree to accept one-half the "A" schedule of Blue Shield benefits for these senior citizens who are in reduced financial circumstances" was referred to this Committee. Blue Shield at present has insured 65,000 people over age 65. Blue Shield has never terminated at their 65th birthday the contracts of those policy holders who were insured before arriving at the age of 65. Those people over age 65 who are employed by a group which is covered by Blue Shield have always been accepted for group enrollment by Blue Shield. So it cannot be truthfully said that the doctors of Florida have completely ignored the medical and hospital insurance needs of the aged. The problem has been to make this coverage available to an even greater proportion of the elderly and to do this in a manner which is actuarially sound or which is not sufficiently unsound to have an adverse effect on the reserves built up by younger policy holders. Finally, because the issuance of a new contract with a new fee schedule and other new features on which no actuarial experience now exists would create a number of problems not only for Blue Shield but for the medical profession, it was the decision of the Committee to discontinue further development of a special "Over 65" contract at the present time. In lieu of this, the Committee requested Blue Cross and Blue Shield to open up their type "F" contracts to this group of people for a period of thirty days, with a six months waiting period for coverage of pre-existing conditions and at rates more closely related to the expected utilization. The Committee was informed that Blue Shield expected no more than 2,000 to 3,000 applications during this time, but that even such a small number of contracts would enable Blue Shield to acquire actuarial data on this age group. With this experience, the problem of issuing a special "Over 65" contract can be more intelligently approached in the future.

Extended Benefits and Master Medical Riders

Early in this year the Blue Shield Board of Directors asked the assistance of the Committee in developing riders to the presently existing "J", "F" and "A" contracts. The Committee was informed that in order to provide the kind of protection that is being sought by the relatively few with higher incomes (the employer, the man who actually decides what group coverage will be purchased for the entire group and who almost invariably evaluates a contract in terms of what it will do for him) and at the same time preserve the unique service benefit features that make Blue Shield so valuable to the bulk of the population, it was imperative that Florida Blue Shield give serious consideration to writing major medical and extended benefits type of coverage. After studying thoroughly all the pertinent facts, the Committee came to the same conclusion and thereupon began a study of details of contracts. It was recommended to the Board of Governors that Blue Shield be authorized to issue extended benefits and Master Medical plan riders. This recommendation was approved. Simultaneously, the Blue Cross Board of Directors was developing extended benefits and master medical plan riders which would be complementary to the Blue Shield riders. In studying these contracts the Committee took the position that:

A. Anything which exerts an influence on the practice of medicine is a proper concern of the physician. Therefore, while this Committee is advisory to Blue Shield, it is within the province of its duties and obligations to consider the Blue Cross provisions which relate to the practice of medicine.

B. There is a fundamental difference between extended benefits and master health plan in that the former is a service contract while the latter is an indemnity contract.

C. The administrative details of handling these contracts are not the proper concern of the doctor so long as they do not affect adversely either directly or indirectly the practice of medicine.

Final approval was given to the sale of: 1. An extended benefits rider to be sold only to policy holders of basic Blue Shield contracts which would in essence extend the benefits beyond the terms of the present contracts (31, and 50 days) for a specified length of time. 2. A master medical plan rider to be sold only to holders of a basic Blue Shield policy which would pay 75 to 80 per cent of the charges incurred in excess of the fees allowed in the Blue Shield schedule with a corrider of $50 to $150 between the basic contract fee and the point where an additional fee would be paid. The Committee felt that it should be made clear in the contract that the addition of the master medical plan endorsement would not change the service benefits status of subscribers whose incomes were below the stated service benefits levels.

Health Insurance of Civil Service Employees

At the request of the President of the Florida Medical Association and upon the invitation of the Blue Shield Board of Directors, the Chairman attended a national conference of Blue Shield Plans in Chicago in October to learn the details of legislation recently passed by Congress providing for the purchase through the Civil Service Commission of prepaid medical and hospital insurance for federal employees. Since that meeting, Blue Shield representatives have been in conference with representative of the Civil Service Commission working out the details of these contracts. At the time of this writing no concrete report on the results of these conferences is available. Undoubtedly, this contract will be a new and different one and will require action by the Blue Shield House of Delegates before Florida Blue Shield can participate. It is the firm conviction of the Chairman after attending the Chicago conference and after studying all of the available information on this matter that Florida Blue Shield should participate in this national Blue Shield coverage for federal employees unless the requirements which subsequently are reported by the negotiating team are completely unacceptable, which is not likely.

The "A" Contract

The "A" Contract is probably the first Blue Shield contract which has been drawn up in which an effort was made to include everything which doctors thought would be desirable. The fee schedule was arrived at after polling every member of the Florida Medical Association, each county medical society and each recognized specialty

society in Florida. "Average", or generally acceptable, fees were allowed for each procedure. Where it was impossible to ascertain a fee or relative value for a specific procedure, the California Relative Value Schedule was used. The net result has been a fee schedule which is considerably higher than any other Blue Shield schedule in the country while the service income limit is 20 per cent to 100 per cent lower than other Blue Shield contracts with comparable schedules. At present writing, in spite of vigorous sales efforts on the part of Blue Shield only approximately 7500 persons are covered by the "A" contract. The reason generally given is that it is too expensive. It is the old story of everyone's wanting a Cadillac until he learns what it costs, then he buys a Ford. Neither this Committee nor the Blue Shield Administration feels that the "A" contract has been a failure. The mere fact of having an alternative to offer to the "J" contract has increased the saleability of the latter. The "A" contract in its comprehensiveness and in its general acceptance by the medical profession has provided a model for the development of other contracts, such as that currently being negotiated with the Florida Industrial Commission.

The "J" Contract

The "J" contract is the basic Blue Shield contract sold to groups. The "F" contract is essentially the same contract but is sold only directly to individuals. The inequities of the "J" contract are self-evident and are generally recognized. At the present premium rates and at the present rate of utilization, the premium dollar is being completely used up. This means that there can be no increase in any fee without a proportionate reduction in another. There can be added no benefits not presently covered without eliminating some that are now covered. The Committee considered recommending a revamping of the "J" contract along the lines of the "A" contract maintaining the same service income limits and premium costs. If this were done, in order to raise the fee for a lobectomy from $150 to $250, the fee for an appendectomy would have to be reduced to about $75. To pay for first day medical care and consultations, the per diem allowance would have to be reduced to $2.50 or $3.00. A correction of the fee schedule inequities of the "J" contract is admittedly needed, but the Committee decided to defer action on this matter until more information as to what would be acceptable to the doctors of Florida was available.

Fee Schedule Changes "A" Contract

While this Committee was not charged with the responsibility of drawing up fee schedules, it did so of necessity in preparing the "A" contract. Since the appearance of this contract, there have been several complaints about fees being out of line, usually too low. As has already been indicated in this report, an opportunity to help draw up this fee schedule was offered every doctor in Florida before it was made. The Committee regrets that more doctors did not voice their objections at that time when it would have been a simple matter to change fees. Now all fee changes not only must receive approval of a preponderance of the medical profession but must be approved by the Insurance Commissioner. The Florida Society of Ophthalmology and Otolaryngology has presented a list of procedures with recommendations for changes in fees allowed in the schedule. Organizations representing other doctors who would be affected by the requested changes have been polled for opinion (the Florida Academy of General Practice, Florida Association of General Surgeons, the plastic surgeons and the thoracic surgeons.) To date this study is not complete. If it is impossible to complete this study before the end of this fiscal year, which now appears likely, it is the recommendation of the Chairman that this matter be referred to the newly appointed Fee Schedule Committee for its consideration.

In conclusion, I would like to make a few personal remarks:

1. I would like to thank Past President Francis Langley for having given me the opportunity four years ago of being a part of this interesting and challenging, if sometimes onerous, aspect of medical organizational work. I would like to thank President Ralph Jack for the privilege of serving as Chairman for the past year.

2. To the members of the Committee, I would like to say that it has been a rare treat to associate with and get to know you gentlemen and I appreciate your interest and faithful attendance at committee meetings.

3. The Blue Shield Board of Directors and the Blue Shield administration have given the Committee every consideration and have cooperated with it to the fullest extent. I am sure that each member of the Committee shares with me the feeling of confidence which I have in those people who are doing such a fine job for the medical profession in Florida.

4. And, finally, I would like especially to express my appreciation to Mr. W. J. Stansell, Manager of Professional Relations Department of Blue Shield. The effectiveness of this Committee has been due in large part to the efforts of Joe Stansell. By constantly traveling from one committee member to another, he has kept us in intimate contact with each other and completely apprised of everything that happened as it happened. It is heartening to know that the medical profession has such energetic and dedicated laymen as this young man working in its interest.

Supplement

On January 15, 1960, the Committee was asked by the Executive Director of Blue Shield for an expression of opinion concerning the willingness of the physicians of Florida to participate in the National Blue Shield coverage for Federal Civil Service employees. This coverage provides for two contracts at different levels of service benefits, one at $6000 and one at $4000 annual family incomes. A vote was taken by telephone and the Committee agreed to recommend to the Board of Governors that approval be given to Blue Shield to participate in this coverage using the original fee schedule and relative value scale presented by the Committee to the House of Delegates in 1958 for the Blue Shield "A" contract. This fee schedule was postulated on a $6000 family income maximum for eligibility for service benefits. At a meeting held on February 7, 1960, the Board of Governors approved the recommendations of the Committee. The $6000 contract is a modification of the present Type "A" Blue Shield contract with certain benefits removed and others added. This is a service contract, which means that people whose family income is $6000 or less cannot be charged by participating physicians more than the fee schedule allows for those services covered by the contract. For those services not covered by the contract the physician is free to charge his usual and regular fee. The $4000 income service benefits contract contains the same provisions as the $6000 except that the Board of Governors approved a fee schedule which would be 4/6 of the $6000 schedule. Subsequently, the Blue Shield Board of Directors raised by 1/6 the fee schedule for medical services under the $4000 so that in every instance the payment for medical benefits would be equal to or greater than those applicable to the present type "J" Blue Shield contract, which has a $3600 family income service benefits ceiling.

In the opinion of the Chairman the lower level contract is the finest of this sort that he has seen. Since it corrects most of the glaring inequities of the "J" contract and has a service income limit only $400 greater, it could be used to supplant completely the "J" contract to the benefit of patient and doctor alike.

After careful evaluation of the changes in the relative value schedule requested by the Florida Society of Ophthalmology and Otolaryngology and further consultation with the officers of this Society, the Committee recommended to the Board of Directors of Blue Shield that these changes be made as requested by the Florida Society of Ophthalmology and Otolaryngology with the provision that there be no increase in total cost to Blue Shield.

Dr. Jelks: "The report of the Medicare Mediation Committee by Dr. Burns A. Dobbins Jr., Chairman, and its supplement are approved as presented.

"The resolution on 'Seeking Guarantee of Payment When Permit DD Form 1251 Is Used', is approved with the change that the last paragraph be deleted and replaced with the following:

> '2. If dependents of sponsors are stationed at military facilities where there are no competent medical officers, that the commanding officer request permit for civilian care from the nearest responsible medical officer.'

"Mr. President, I move the adoption of this portion of the report as amended."

Motion was seconded.

Dr. W. Dean Steward: "I realize the House is probably tired of seeing me appear before it on this subject, but I feel very strongly about it and I would like to make a statement or two first to clarify conditions. What we do does not affect Medicare—it is the law. However, what we do affects how Medicare is implemented. All of you realize that the Army has had contract physicians for many years. Under Medicare law this can be continued. It merely means that the Florida Medical Association will not be condoning and assisting in the practice of socialized medicine. Dr. Orr told earlier of our all-out fight against the Forand Bill. My friends tell me to get up here is foolish, a waste of time, that Medicare exists and will continue to exist and we can do nothing about it. I disagree. I think that unless we stand up and fight, this situation, which has existed for three years and which everyone accepts, will not only continue to exist but other measures will be brought forward which we will oppose temporarily and then, because the situation persists and is there, we will continue. I would like to point out to you that we are in a very dangerous situation. I am sure this needs no emphasis. I have told my friends that if they can give me any valid reason why I should stop opposing Medicare I would be glad to do so. Not one has come forward with a valid reason. They say the other states are doing it, that the AMA has approved it, and therefore we should go along. Texas, as you know, withdrew; it has been said that Texas is going back in or is considering it. Oklahoma is out. Why can't Florida lead in this very dangerous fight? It would appear to me that the action of the House of Delegates last year, when we voted to discontinue the state participation in Medicare unless the government adopted an insurance program, can be reaffirmed this time. I would strongly urge that the House consider this and vote against this portion of the Medicare Committee's recommendation. I would further urge that this House submit a resolution to be carried to the American Medical Association explaining our view on this, that it can be done under contract physicians. Thank you."

Dr. Burns A. Dobbins Jr.: "I assure you that I am not trying to federalize anything but, as Dr. Steward so ably pointed out, Medicare is with us and if we don't attempt to guide it in the direction in which we would like it to go, it is possible we will be losing even more. It is purely selfish as I pointed out earlier, for we will be looking after our own physicians who need our help and will be able to represent them, we will be able to look after our patients who we know should be taken care of and who are entitled to Medicare, plus the fact that it would give us a black eye now if it were spread on the front pages that the Florida Medical Association is deserting the dependents of military personnel. So I think from a public relations standpoint alone, we should continue Medicare. I respect Dr. Steward's viewpoint; he is an arch-conservative in this matter and as I pointed out to the Reference Committee, we need both sides represented to keep a balance of judgment. But many of you also remember that the same stand was taken on voluntary insurance about 25 years ago, and there were many who were very opposed to it, but now we are looking to voluntary insurance as our savior."

Dr. Jelks' motion for approval of this portion of the report was carried.

Report of Medicare Mediation Committee

BURNS A. DOBBINS JR., *Chairman*

During the period May 1, 1959 to February 1, 1960, the Medicare Mediation Committee held five meetings—one at the Americana Hotel in Bal Harbour, one at the County Health Department Building in Gainesville, and the others at the F.M.A. Building in Jacksonville. Attendance at the meetings has been excellent. Claims totaling 9,094 have been paid by Blue Shield as fiscal administrator from February 1, 1959 to February 1, 1960, for a total of $854,698.86 to Florida physicians.

The committee considered 507 claims between May 1, 1959 and February 1, 1960, 294 less than during the previous year, which was due to the curtailment of the Medicare program on October 1, 1958. Many hours have been spent by each member, both in and out of committee meetings, considering these claims. However, the

task would have been infinitely more difficult except for the splendid work and cooperation of the County Medicare Committees. These local groups, as an integral part of the Medicare organization, have performed their duties most conscientiously and have relieved the State Committee of a tremendous amount of work, for which it is most grateful.

Effective January 1, 1960, dependents' benefits under the Medicare program have been restored, almost to the same degree as the original program. The only restriction now in effect, which was not included in the original program, is that dependents living with sponsors must have a permit for civilian care; and the only other change in benefits is the deletion of termination and neonatal visits from the medical schedule.

A word of caution about these permits—they carry no guarantee that the physician will be paid for the service rendered. It is still the responsibility of the physician to determine whether the service requested is compensable under Medicare. Your committee will continue to protest this provision; if the military authorities cannot determine whether or not a service is compensable at the time the permit is issued, the civilian physician should not be expected to do so.

Supplement

When this House of Delegates adjourned last year, the Medicare Mediation Committee was instructed to pursue the idea of an insurance plan for dependents of the Armed Services with the Office for Dependents' Medical Care. A report on our efforts toward this insurance plan was made at the meeting last year.

I cannot report any success with our proposed insurance plan. However, I do feel that partly through our efforts toward the insurance plan in acquainting the members of Congress with the fact that the Medicare Program, as curtailed October 1, 1958, was not carrying out the intent of Congress in Public Law #569, the program was reinstated January 1, 1960. As a matter of fact, except for the maternity benefits, dependents, after October 1, 1958, were not a whole lot better off than they were before the Medicare Program went into effect. The major reason advanced for the rejection of the insurance idea for dependents of the Armed Services as compared to other Federal employees, is that the Medicare Program was designed to supplement the medical program of the Armed Services to permit the use of civilian medical facilities where there were no military medical installations. Also, the concept of Medicare was endosed by the American Medical Association to prevent the enlargement of Armed Service medical facilities and thereby curtail as much as possible the discriminatory doctor draft program.

As a result of our representations to Congress, the pleas of other groups, and the requests from the Office for Dependents' Medical Care, effective January 1, 1960, the program was restored to essentially what it was prior to the curtailment October 1, 1958. The principal exception is that now dependents who live with their sponsors must have a special permit before they can obtain civilian medical care. At this time, I want to caution all physicians to acquaint themselves with the provisions of these permits and to warn you that merely possessing this permit does not guarantee payment for all services. Your committee does not like the present system of permits. If this House of Delegates wishes to continue the contract of the Florida Medical Association with the ODMC, our committee has drawn up a resolution which is in your folder which we would like to see adopted.

To get along with the report, let us have the first slide. As you see, even though the Program was cut back considerably during the 1959-60 period, still 1,564 of our members participated and received $934,540.

Our second slide shows the extent to which various physicians participated. You will note that one physician received $16,189. Quite frankly, I was not even familiar with this physician's name. His office handles such a volume of Medicare reports that he understands the regulations and the forms. It is for the protection of those members who received the much lesser amounts and naturally cannot be as well acquainted with the program that our resolution is directed.

It is interesting to note in the next slide to what extent the various counties have participated in Medicare. The amounts paid to physicians in the top seven counties are listed.

In the next slide we would like to point out to you the amounts that have been paid out to Florida physicians in the various periods since the inception of Medicare. Also, the anticipated amount that will be paid between January, 1960, and July, 1960, is projected.

At the present time, the various state Medical Associations operate their Medicare Program in three ways. One group publishes a fee schedule and sends to all physicians, another group has never published a fee schedule, the third group published a fee schedule originally, but later withdrew the schedule and asked that physicians charge fees prevailing in their particular neighborhood for the $4,500 income group. Florida is in the third category. It is interesting to note that according to ODMC statistical data for each $150 of services in the states where they publish the fee schedule the cost is $150.93. In the second category, those who have never published a fee schedule, the cost for the same $150 of services is $120.46. And, in the third group, including Florida, the cost of each $150 of services is $131.10. So you see, the action this House of Delegates took in 1957 has saved the taxpayers some money.

I am happy to report that the chairman of your Committee has continued his post-graduate medical education during the past year. He is continually learning new terms and procedures which he did not know existed! However, he is particularly fortunate in having such a learned group as members of the Committee who can usually supply the answers. As the Chairman, I am indeed grateful to the Committee members, not only for their knowledge, but for the long hours they put in, both in the Committee meetings which have been held approximately every two months, and the considerable time spent studying claims between meetings. These members are: Dr. Brooks Brown of Jacksonville, Dr. Maxey Dell Jr. of Gainesville, Dr. Frank Hodnette of Pensacola, Dr. Thomas McKell of Tampa, Dr. John Milton of Miami and Dr. Charles Sias of Orlando. To be quite truthful, it would have been almost impossible for the Medicare Mediation Committee to function without the very fine co-operation and assistance we have had from Mrs. Mae Mason, Secretary, Mr. Al James of the FMA, and Mr. N. G. Johnson, Medicare Co-ordinator from Blue Shield.

I feel that I would be negligent if I did not again call your attention to the fine work that the local County Committees do for Medicare. These Committees take a tremendous load off the State Committee and make decisions where they should be made at the county level. In this respect, I feel that the Florida Medical Association has the best system for handling Medicare claims of any state in the country.

It is the recommendation of your Medicare Mediation Committee that the Florida Medical Association continue to co-operate in caring for the medical needs of the dependents of the Armed Services and extend its contract with the Office For Dependents' Medical Care. The recommendation is based on four points. First, a large percentage of our members participate in the program and the interest of these physicians can be better represented by the Florida Medical Association than each individual physician can do for himself. Second, although a great deal of time is spent by the County and State Medicare Committees in adjudicating claims, we feel that it is more advantageous to the physicians and to the taxpayers to have any differences settled on the local and state level rather than by some disinterested company or the ODMC. Third, at this time when the medical profession

is striving for better rapport with the public, we feel that it would be poor public relations for the Florida Medical Association to withdraw from a plan that was sponsored by the American Medical Association and the co-operation of organized medicine was solicited. Fourth, the failure of the Florida Medical Association to enter into a contract for these dependents' care would not mean that Medicare would stop. All claims would then be forwarded to a disinterested company, such as Mutual of Omaha, which now handles the hospital claims, for payment. Each physician would be on his own whenever a difference of opinion arose.

It is true that the concept of Medicare is somewhat of a change from previously established policies. However, all things are constantly in a state of change and your committee feels and recommends that we take part in this change and make it as advantageous to us as possible. We cannot ignore Medicare and act like an ostrich and bury our heads in the sand, because if we do like the ostrich, we will have very vulnerable parts exposed and you can see what will be knocked off first.

Resolution

Seeking Guarantee of Payment When Permit DD Form 1251 Is Used

WHEREAS: Effective January 1, 1960, essentially all benefits provided under Public Law #569 have been restored to the same status that existed prior to October 1, 1958, with one notable exception;

WHEREAS: This notable exception is that dependents residing with their sponsors must have a permit (Nonavailability Statement, Dependents' Medical Care Program, DD Form 1251, January 1, 1960) from the competent military authority before seeking civilian medical care, except in cases of emergency;

WHEREAS: This permit may be issued by nonmedical people and even when issued by Medical Officers, carries no guarantee of payment. The responsibility of whether or not the service requested is allowable under Public Law #569 is placed upon the civilian physician, who may or may not have had experience in dealing with the Medicare program, and may not be familiar with the various ramifications of the law, and the limitations imposed by the Office for Dependents' Medical Care;

WHEREAS: This condition of issuing permits for non-authorized care often creates a great misunderstanding on the part of the dependent involved, the issuing Military Authority, and the civilian physician who is trying to provide a service, with resulting ill feelings on the part of all concerned:

BE IT THEREFORE RESOLVED: That the Florida Medical Association request that its Delegates to the American Medical Association introduce a resolution to that body requesting that the Federal Medical Services Committee of the American Medical Association negotiate with the Office for Dependents' Medical Care along these lines:

1. That permits for civilian care be issued only by competent Medical Officers, familiar with the provisions of Public Law #569, and, when issued, such permit will constitute a requisition for the requested medical service, thereby eliminating any question of payment because the service is not authorized.
2. If dependents of sponsors are stationed at military facilities where there are no competent medical officers, that the commanding officer request permit for civilian care from the nearest responsible medical officer.

Presented by
FMA Medicare Mediation Committee

Dr. Jelks: "The report of the Editor of The Journal, Dr. Shaler Richardson, is approved as presented with commendation to the Editor.

"Mr. President, I move the adoption of this portion of the report."

Motion was seconded and carried.

(The Editor's report appears on page 1552 of this issue.)

Dr. Jelks: "The resolution on pension fund for physicians presented by Dade County Medical Association is approved in principle and your Committee would like to call to the attention of the House that the Florida Medical Foundation has as one of its objectives aid to needy physicians.

"Mr. President, I move the adoption of this portion of the report."

Motion was seconded and carried.

Resolution

Pension Fund for Physicians

WHEREAS, the medical profession with a membership of nearly 200,000 has failed to create some form of assistance for its members who, through adverse circumstances, advanced age, infirmities or similar situations, are unable to provide for themselves and their families, and

WHEREAS, some provision should be created for members of the profession who might unfortunately fall into the above category; therefore

BE IT RESOLVED, that the delegates of the Florida Medical Association to the American Medical Association seek the creating of an assistance fund governed by an adequate and competent committee of the AMA, and

BE IT FURTHER RESOLVED, that this fund be supported by assessment of the AMA membership and that only members of the AMA in good standing shall be eligible for benefits from this fund.

Presented by
DeWitt C. Daughtry, Secretary
Dade County Medical Association

Dr. Jelks: "The resolution on an interim meeting, presented by the Broward County Medical Association is approved as presented.

"Mr. President, I move the adoption of this portion of the report."

Motion was seconded and carried.

Resolution

Interim Meeting

WHEREAS, there is an increasing amount of business that should be acted upon by the House of Delegates between Annual Sessions of the Florida Medical Association, and

WHEREAS, the Annual Meeting of the newly elected Presidents and Secretaries of the component county societies has proven its worth and should be annually scheduled, and

WHEREAS, there are many committees that need to have a definite time of meeting between the regular sessions of the Florida Medical Association, and

WHEREAS, there are some special interest groups who may be interested in having Fall meetings in con-

junction with a meeting of the Florida Medical Association;

NOW THEREFORE, BE IT RESOLVED, that the House of Delegates request that the Board of Governors of the Florida Medical Association investigate the feasibility of holding an Interim Meeting annually between October 15 and November 15, and,

BE IT FURTHER RESOLVED, that such a meeting be held either

1. in a section of the state different from that of the Annual Meeting of the same year, or
2. on a cruise ship sailing from a Florida port, or
3. in one of the adjacent Caribbean Island resorts.

Presented by
Broward County Medical Association

Dr. Jelks: "The resolution on adoption of a relative value scale presented by the Orange County Medical Society, is approved as presented.

"Mr. President, I move the adoption of this portion of the report."

Motion was seconded and carried.

Resolution

Relative Value Scale

WHEREAS there is no coordination in fee for service schedules between those various governmental and social agencies which provide for payment of medical services, and

WHEREAS fee schedules tend to become rigid and subject to very infrequent revision, and

WHEREAS the physicians of Florida should have a voice in determining fee schedules and the relative value of medical services, therefore

BE IT RESOLVED that the Florida Medical Association approve the adoption of a relative value scale of medical and surgical procedures as a basis for establishing fee schedules, and

THAT the relative value schedule of Blue Shield "A" Contract be adopted as the official Florida Medical Association's relative value schedule, and

THAT all negotiations with any governmental or social agencies which desire to adopt a fee schedule approved by the Florida Medical Association be based upon the use of this official relative value schedule, and

THAT the variable factor subject to negotiation in adopting fee schedules be the conversion factor only, and

BE IT FURTHER RESOLVED that the relative value schedule be under constant study by the Fee Schedule Committee which will make periodic recommendations to the Board of Governors of the Florida Medical Association for changes in the relative value schedule to reflect changes in medical practice, and

THAT the Board of Governors of the Florida Medical Association be empowered to authorize the recommended changes.

Presented by
Orange County Medical Society

Dr. Jelks: "Your Committee considered the resolution on Compulsory Membership, presented by the Dade County Medical Association, and recommends that the Board of Governors be requested to make a study of the problem arising from the different types of membership classifications in the various component county medical societies and to adopt measures for their solution.

"Mr. President, I move the adoption of this portion of the report."

Motion was seconded and carried.

Dr. Jelks: "The resolution on the appointment of county public safety committees, presented by the Medical Advisory Committee to the State Department of Public Safety, is approved as presented.

"Mr. President, I move the adoption of this portion of the report."

Motion was seconded and carried.

Resolution

Appointment of County Public Safety Committees

WHEREAS, the Medical Advisory Committee to the State Department of Public Safety, which is provided by the Florida Medical Association, is little known to the physicians in Florida, and

WHEREAS, this committee's job of screening applicants with physical and mental handicaps for license to operate motor vehicles is becoming more difficult and time-consuming, and

WHEREAS, the physical form requested by the Department of Public Safety is at times incomplete and illegible,

THEREFORE BE IT RESOLVED, that the Florida Medical Association recommend to the county societies that a committee of public safety be appointed so that the State Committee may utilize their help in problems arising in their areas.

Presented by
FMA Medical Advisory Committee to the
Florida State Department of Public Safety

Dr. Jelks: "Mr. President, I move the adoption of the entire report."

Motion was seconded and carried.

Report of Reference Committee No. 4

Legislation and Miscellaneous

Dr. Edward W. Cullipher: "Mr. President, and members of the House of Delegates: Your Reference Committee of which I had the pleasure of serving as Chairman, with the very able help of Drs. Walter E. Murphree, Marion W. Hester, Ralph M. Overstreet Jr. and Robert F. Dickey, gave careful consideration to items referred to it and makes the following report:

"Regarding the report of the Committee on Legislation and Public Policy by Dr. H. Phillip Hampton, Chairman, the supplemental report by Dr. Hampton and the second supplemental report by Dr. Edward R. Annis, we recommend acceptance of the report as published in the Handbook down to the middle of page 50, that part dealing with the Medical Practice Act. We further recommend substitution of the part of the report of the Revised Medical Practice Act, contained in the delegates' packets, with the exclusion of 458.06, paragraph 2(e) 'Applicants for licensure under this chapter are not required to qualify under the Florida Basic Science Law and provisions of Chapter 456, Florida Statutes are expressly declared to be inapplicable to applicants for licensing by the State Board of Medical Examiners.' Also the exclusion of 458.13, paragraph (2) 'In addition to the foregoing the Board may revoke the license of any physician who has not practiced medicine in this state within ten years of obtaining license to do so.' Also the exclusion of 458.18, 'Privileged Communications,' paragraphs (1), (2), (3) and (4), because we felt this should be better as a separate law and that it would be well not to include it in the Medical Practice Act.

"Mr. President, I move the adoption of this entire report as amended."

Motion was seconded.

Dr. Anthony C. Galluccio of Broward: "I move that the motion on the floor be amended to the extent that paragraph 458.08 dealing with temporary licensure be deleted.

"While this may have been sorely needed years ago and in spite of that very inextensively used, certainly with the amount of medical manpower the state now enjoys there is even less need for this clause. Too, it may represent a back door to the practice of medicine in the State of Florida and also it may be used as a means for political pressure to gain practice of medicine in the State of Florida."

Amendment to motion was seconded and carried.

Dr. Cullipher's motion for approval of this portion of his report was carried.

Report of Committee on Legislation and Public Policy

H. PHILLIP HAMPTON, *Chairman*

In April 1959 the House of Delegates of the Florida Medical Association approved the report and recommendations of the Governor's Citizens Medical Committee on Health. Subsequently the Florida Legislature, in accordance with these recommendations, amended the law providing hospital service for the indigent to include outpatient care and ancillary home services for the indigent sick.

The state appropriation to implement this law was divided into two parts, one part to be matched with federal funds to provide hospital services for the indigent who fit into the four federal categories of public assistance, and the other part to match county funds to provide hospital services for the indigent who are county general assistance recipients. In order to obviate two separate indigent care programs the Legislature allowed for a contractual agreement between the State Welfare Department and the State Board of Health so that all indigent health services are provided in one program under the State Board of Health. During the biennium almost ten million dollars of federal, state and county funds will be spent through this program to provide hospital services for acutely ill indigent in Florida, but already the funds have been found insufficient to pay the hospital costs of non-resident indigents, such as migratory workers.

The future development of this program will largely depend upon the action of this session of the Congress. If Forand type law is passed, it will become the right of each social security recipient to have a certain number of days of hospital and surgical care each year paid for by federal social security funds. This will establish a pattern of government medical services easily expanded to include the entire population.

It is extremely unlikely the Congress will avoid increasing welfare benefits in an election year, but it is possible it will be content with minor modifications of existing programs providing medical care for those in need and without the means of paying for it themselves.

The Florida program to provide for the health needs of the indigent sick created under the guidance of the Florida Medical Association and administered through the State Board of Health now offers the physicians of Florida the opportunity to assume the responsibility and supervision of medical care for the indigent of the state. By agreement with the State Board of Health, the Florida Medical Foundation may implement and administer the program of indigent outpatient care and ancillary services provided for by Florida law. Just as the House of Delegates of the Florida Medical Association acting as the corporate body of Blue Shield determines the policy and administers the program to provide medical services

for the marginally indigent, so the Florida Medical Foundation (whose directors are the Board of Governors of the Florida Medical Association) can determine the policy and administer the medical program for care of the legally indigent.

Creation of a statewide medical care program for the indigent by the Florida Medical Foundation will provide a means of promoting postgraduate medical education, curtailing indigent medical care costs, and preventing further increases in costs of hospital care by the only people who can do it—the practicing physicians.

State Legislation

Primary objective of the Association during the 1959 session of the Florida Legislature was directed to the support of Governor LeRoy Collins' health program. The Governor's health program was based on the report and recommendations of the Citizens Medical Committee on Health. Those recommendations for which legislation was introduced and passed consisted of the following:

Hospital Service for the Indigent, Chapter 401, Florida Statutes, was amended to authorize an extension of the Indigent Care Program so as to provide out-patient clinic and visiting nurse services for both acutely ill and chronically ill indigents.

Voluntary Health Organizations engaged in the solicitation of funds in two or more counties of the state are required to register annually with the Secretary of State and file budgetary and activity reports. Hospitals and certain fraternal organizations are exempt from the provisions of this act.

Naturopathy—The committee substitute bill as passed revokes all non-resident naturopathic licenses and terminates licensure of additional naturopaths by abolishing the licensure powers of the Board of Naturopathic Examiners. Those naturopaths licensed prior to the enactment of this law may continue to practice as in the past without restrictions.

Those recommendations for which legislation was introduced but failed to pass consisted of the following:

Nursing Home Care—This bill amending Chapter 409, Florida Statutes, would have authorized the Department of Public Welfare to institute a nursing home care program for public assistance recipients. Financing of this program was to be through county, state and federal contributions and would have required mandatory participation by the counties.

Coordinated Single Agency Purchasing—This bill amending Chapter 381, Florida Statutes, would have authorized the State Board of Health to purchase for the State Department of Public Welfare all hospital and medical vendor services, and prescribed drugs for public assistance recipients. Though this bill failed to pass, portions of the provisions contained therein were a part of the amendments to the Hospital Service for the Indigent Law that did pass.

In addition, legislation sponsored by the Association amending the insurance statutes was introduced but later withdrawn from further consideration in deference to passage of the revised insurance code. This bill provided that the insurance laws be amended to permit members and employees of members of professional associations the privilege of group life insurance which is now afforded others where there is an employer-employee relationship, members of labor unions, etc.

Other legislation of interest to the Association which passed consisted of the following:

Hospital Service for the Indigent was further amended, thereby adding licensed doctors of osteopathy to those authorized to certify medically indigent persons for hospital service by the State Board of Health.

Medical Student Scholarships, Chapter 57-406, Florida Statutes, was amended to permit the State Board of Health to permissively award one scholarship each year to a candidate for the degree of osteopathy.

State Tuberculosis Hospitals—The Senate resolution as adopted provides for continued study and investigation of all matters relating to the state tuberculosis hospitals.

Legislation which failed to pass included:

Anti-Fluoridation—This bill would have prohibited the addition of any medicine, drugs, fluoride compounds or any other substance to public water supply systems.

Physical Therapy Practice Law—This bill would have amended the Grandfather Clause in the Physical Therapy Law thereby permitting registration of certain individuals who were previously rejected.

Nurse Practice Act—This bill would have amended that section of the Nurse Practice Act relating to qualification of applicant for licensure as practical nurse. The amendment permitted practical experience in lieu of completion of a course of study in practical nursing in an accredited school.

Chiropractic Practice Act—This amendment provided that (1) chiropractic physicians would have the use and privileges of services of any state, county or municipal laboratory supported by public tax money, (2) chiropractors' testimony relative to analyzing and diagnosing the physical conditions of the human body be accepted and paid for on a parity with other professional services by any agency of the state, county or municipality administering relief or health services. After deletion of these objectionable features the remainder of the bill relating to administration of the chiropractic practice law passed.

National Legislation

This being an election year it is anticipated that many important measures vital to the interest of the health of the nation are to be considered during this Second Session of the 86th Congress. Of all health matters receiving Congressional consideration, there are two pieces of proposed legislation of vital importance to the individual practicing physician and organized medicine.

First, is the Smathers-Morton-Keogh-Simpson Bill which would permit self-employed persons to defer income tax each year on a portion of their income to provide for retirement. Limitations are that a self-employed person would be permitted to set aside annually up to $2,500 or 10% of his income, whichever is less, but not more than a total of $50,000 during his lifetime. The objective of this legislation is to encourage self-employed persons to save for old age and retirement out of current income by providing a valuable tax deferment advantage.

Second, and of equal importance, is the Forand Bill—the purpose of which is to amend the Social Security laws to provide for health benefits for Social Security recipients. The end result, if passed, would be a significant step toward national compulsory health insurance. Therefore in this regard, the Association's current legislative activities are aimed at stimulating active support toward defeat of this type legislation.

A supplemental report outlining current legislative developments will be submitted.

Revised Medical Practice Act

BE IT RESOLVED BY THE LEGISLATURE OF THE STATE OF FLORIDA:

Section 1. Chapter 458, Florida Statutes, 1961, is created to read:

458.01 *Purpose.*—Recognizing that the practice of medicine is a privilege granted by legislative authority and is not a natural right of individuals, it is deemed necessary by the legislature in the interests of public health, safety and welfare to provide laws and provisions covering the granting of that privilege and its subsequent use, control and regulation to the end that the public shall be properly protected against unprofessional, improper, unauthorized and unqualified practice of medicine and from unprofessional conduct by persons licensed to practice medicine.

458.02 *Board of medical examiners; qualifications.*—A board is established known by the name and style of the state board of medical examiners; said board shall be composed of ten practicing physicians of integrity and

ability, who shall be residents of and duly licensed to practice medicine in this state, and who shall have graduated from reputable medical schools and have been engaged in the active practice of their profession within this state for at least a period of five years, but none of them shall be connected in any way with any medical college; said board shall perform such duties and possess and exercise such powers relative to the protection of the public health and the control and regulation of the practice of medicine in the state as is prescribed and conferred upon it in this chapter.

458.03 *How board constituted.*—The governor shall appoint ten physicians who shall possess the qualifications specified in § 458.02 to constitute the members of the board of medical examiners. Said members shall be so classified by the governor that the term of office of two shall expire in one, three in two, two in three and three in four years from the date of appointment. Annually thereafter at the end of said terms the governor shall appoint members who shall serve for a term of four years. The governor shall have power to remove from office members of the board for neglect of duty required by this law, for incompetency or for unprofessional conduct. Any vacancy which may occur in said board in consequence of death, resignation, removal from the state or from other cause shall be filled for the unexpired term by the governor in the same manner. A majority of the board shall constitute a quorum.

458.04 *Oath of members of board.*—Immediately and before entering upon the duties of said office the members of the board of medical examiners shall take the constitutional oath of office and shall file the same in the office of the secretary of state; and there shall thereupon issue to said member a certificate of his appointment.

458.05 *Organization of board; meetings.*—Immediately after the appointment and qualification of its members, the board of medical examiners shall meet and organize. Said board shall elect a president, vice-president, secretary and treasurer from its membership. The office of secretary and treasurer may be held by one person. Members of the board shall receive ten dollars per day, or any part of a day, while attending official board meetings, not to exceed twelve meetings per year, and shall receive per diem and mileage as provided in § 112.061, from place of their residence to place of meeting and return. All expenses of the board shall be paid out of the state agencies fund. The secretary shall be paid an annual salary of twelve hundred dollars.

Said board shall hold two regular meetings each year at some convenient place in the state and on such date as the board may select, of which meetings notice shall be given by publication thereof once a week for four successive weeks in a newspaper of general circulation throughout the state. Special or call meetings may be held at the discretion of the president. Said board shall adopt a seal, which must be affixed to all licenses issued by it. The board shall from time to time adopt such rules and regulations as it may deem necessary for the performance of its duties, and shall examine and pass upon the qualifications of applicants for the practice of medicine in this state as provided in this chapter.

458.051 *Assistant secretary; employment, compensation.*—

(1) The state board of medical examiners may appoint or employ an assistant secretary or secretaries, and such other personnel, including but not limited to an executive director and investigators, as may be necessary to assist the board in doing and performing any and all of the powers, duties and obligations set forth in this act. Such personnel need not be licensed physicians or members of the said board. The assistant secretary or secretaries shall act as deputies to and under the secretary of the said board and shall be authorized to do and perform any and all of the powers, duties and obligations of the said secretary of the board as may be assigned by the secretary or the board.

(2) The compensation to the assistant secretaries and other personnel of the board of medical examiners shall be fixed by the said board and paid in the usual manner.

458.06 *Application for license; qualifications of applicant.*—

(1) Any person wishing to practice medicine in this state, who has not heretofore been registered or licensed so to do, shall, before practicing in this state, make application to the board upon such form and in such manner as shall be adopted and prescribed by it, and obtain a license. Unless such person shall have obtained a license as aforesaid, it shall be unlawful for him to practice medicine in this state, and if he shall so practice medicine, he shall be deemed to have violated the provisions of this chapter.

(2) The board shall admit to examination any candidate who pays the fee provided for in this chapter and submits evidence verified by oath, satisfactory to the board, that such applicant:

(a) Is more than twenty-one years of age and a citizen of the United States;

(b) Is of good moral character;

(c) Is a graduate of a medical school or college maintaining a standard and reputability approved by the board pursuant to § 458.09;

(d) Has completed at least one year of approved internship or at least five years of private practice.

(3) Notwithstanding the provisions of sub-paragraph (c) of sub-section (2) of this section, graduates of foreign medical schools, except approved schools in Canada, who are otherwise qualified and whose medical credentials have been evaluated by the educational counsel for foreign medical graduates and who have passed the american medical qualification examination for foreign medical graduates, may be accepted for the examinations in Florida.

458.07 *Recording of license; registration.*—

(1) Every license to practice medicine shall, before the licensee begins practice thereunder, be recorded in a book for that purpose in the office of the clerk of the circuit court of the county in which he resides, or in which such practice is intended to be carried on, or with the clerk of the circuit court in Leon county, Florida, with the name, residence, place and date of birth and source, number and date of his license to practice. Before registering each licensee shall file, such file to be kept in a bound volume in the office of the clerk of the circuit court, an affidavit of the above facts and also that he is the person named in such license and had before receiving the same complied with all the requirements as to examination required by law; that no money was paid for such license except the regular fee paid by all applicants therefor, that no fraud, misrepresentation or mistake in any material regard was employed by any one or occurred in order that such license should be granted. The clerk's fee for recording such license and affidavit shall be the same as for recording a deed; provided, however, that the clerk of the circuit court shall not accept for recording, and shall not record any such license to practice medicine dated after the effective date of this law unless the same shall be presented to him for recording on or before the expiration of sixty days after the date of such license, or the date of the recertification thereof by the board of medical examiners; provided, further, that no license to practice medicine dated prior to the effective date of this law may be recorded by the clerk of the circuit court unless the same shall be presented to him for recording on or before the expiration of six months from and after the effective date of this law, or within sixty days after the date of recertification thereof by the board of medical examiners. The circuit court clerk of each county shall make report to the secretary of the board of medical examiners on the thirty-first day of December of each year of all certificates registered by him.

(2) Every person now lawfully engaged in the practice of medicine and every person hereafter duly licensed to practice medicine, shall, on or before January first of each year, apply to the secretary of the state board of medical examiners for a certificate of registration upon a blank form to be furnished by such secretary and shall pay at such time a fee of ten dollars. The license of any physician who fails or neglects to register by January first of any year, as required herein, shall automatically be suspended until such time as such physician shall register and shall pay the regular annual fee plus a delinquency fee of ten dollars for each year or fraction thereof that he failed to register.

(3) A physician in making his first registration hereunder shall write or cause to be written upon the application blank so furnished by the secretary of the state board of medical examiners, his full name, post office and residence address, the date and number of his license and such other facts for the identification of the applicant as a licensed practitioner of medicine as may be deemed necessary, and shall duly execute and verify the same before an officer authorized to take acknowledgments of deeds and shall file the same with the secretary of the board. Registration subsequent to the first registration need not be upon sworn application, unless the board, in a particular case, for reasons satisfactory to them, may require that application be under oath.

(4) The secretary of the state board of medical examiners on or before October first of each year, after the first registration, shall mail or cause to be mailed to each registered physician, a blank form of application for registration addressed to the last known post office address of such physician. The form of such application shall be such as to contain space for the insertion by the applicant of the information required by the provisions of this chapter.

(5) The secretary of the state board of medical examiners shall issue to any duly licensed physician in this state upon his application therefor in accordance with the provisions hereof, a certificate of registration under the seal of the board for the year ensuing and ending December thirty-first.

(6) Each licensed physician shall conspicuously display his proper registration certificate in his office at all times.

458.09 *Board to pass upon medical college schools, hospitals, etc.*—

(1) The board of medical examiners may pass upon the good standing and reputability of any medical school or college and determine those which maintain a standard of training sufficient to admit their graduates to the medical examinations given by the said board.

(2) The said board may also pass upon the good standing and reputability of any hospital and determine those which maintain a standard of training sufficient to be recognized by the board.

(3) In determining the good standing and reputation of medical schools and colleges, and of hospitals, as aforesaid, the board may investigate and make a personal inspection thereof, or delegate to one or more of its members or any other duly qualified person or persons, the power and authority to make such investigation for the board and report their conclusions to the board. The board may, if satisfied of the correctness of the same upon investigation, adopt inspections of medical schools and colleges and hospitals made by, or under the authority of, the American Medical Association or other nationwide groups.

458.10 *Examination of applicants.*—The examination of applicants for license to practice medicine shall be made by the board of medical examiners according to the methods deemed by it to be the most practical and expeditious to test the applicants' qualifications. The board shall require the examination to be in writing. Each applicant shall be designated by a number instead of by name so that his identity shall not be disclosed to the members of the board until after the examination papers are graded. Examinations shall be in selected categories to appropriately include the various fields of the practice of medicine and surgery, including the recognized branches or specialties and also including clinical applications of the basic sciences. Subjects in which examinations are to be given will be available six months before the examinations are given.

458.11 *Fees.*—There shall be paid to the secretary-treasurer of the board of medical examiners by each applicant for license by examination a fee of fifty dollars which shall accompany the application. All fees collected shall be deposited in the state treasury to the credit of the state agencies fund. No part of any fee is returnable under any circumstances, nor shall this chapter be construed as affecting or changing laws in reference to license tax to be paid by physicians and surgeons.

458.12 *Powers of board; prosecutions.*—The board of medical examiners may administer oaths, summon witnesses and take testimony in all matters relating to its duties. Said board shall issue license to practice medicine to all persons who shall furnish satisfactory evidence of attainments and qualifications under the provisions of this chapter, and the rules and regulations of the board. Such license shall be signed by the president and attested by the secretary-treasurer of the board under its adopted seal, and it shall give absolute authority to the person to whom it is issued to practice medicine in this state. Every unrevoked license and indorsement of recordation made as provided in this chapter shall be presumptive evidence in all courts and places that the person therein named is legally licensed to practice medicine. The secretary-treasurer, under the direction of the board, personally or by deputy, shall aid the prosecuting attorneys of the state in the enforcement of this chapter and in the prosecution of persons charged with violation of its provisions.

458.13 *Revocation, suspension, annulment or denial of license.*—

(1) The board shall have authority to discipline the holder of a license or other authority to practice medicine in this state, and each applicant for license, whose default has been entered or who has been heard and found guilty by the board, of any of the following:

(a) Fraud in the practice of medicine, or fraud or deceit in his admission to the practice of medicine; or through a mistake by the board in his admission to the practice of medicine;

(b) Conviction of a felony in the courts of this or any other state, territory or country. The conviction of any offense in another state, territory or country, which if committed in this state would be deemed a felony shall be held to be a felony under this section without regard to its designation in such other state, territory or country;

(c) Engaging in the practice of medicine under a false or assumed name, or the impersonation of another practitioner of a like, similar or different name;

(d) Addiction to the habitual use of intoxicating liquors, narcotics or stimulations to such an extent as to incapacitate him from the performance of his professional obligations and duties;

(e) Untrue, fraudulent, misleading or deceptive advertising, advertising that he is able to treat or cure disease by any secret method, procedure, treatment or medicine; or that he is able to cure a manifestly incurable disease;

(f) Obtaining a fee, or other things of value, on representation that a manifestly incurable disease can be permanently cured;

(g) Causing the publication or circulation of an advertisement of any medicine whereby the monthly periods of women can be regulated, or the menses, if suspended, can be re-established;

(h) Causing the publication or circulation of fraudulent advertisement relative to any disease of the sexual organs;

(i) The procuring, aiding or abetting in procuring of criminal abortion;

(j) Is guilty of immoral or unprofessional conduct;

(k) Maintains a professional connection or association with any other person who continues to violate the provisions of this chapter, or the rules and regulations of the board duly made pursuant thereto, after ten days' notice in writing by the board;

(l) Has been adjudged insane by a court of competent jurisdiction (within or without this state). Where a person has been so adjudicated he shall be deemed disqualified to practice medicine in this state so long as such adjudication shall remain in full force and effect and the disabilities of such person have not been judicially restored; unless the board shall, after a full hearing, order otherwise.

(2) In disciplining any person for violating the provisions of this section, or any other statute or law of this state or any other state relating to the practice of medicine, the board may:

(a) Suspend the imposition of judgment and penalties;

(b) Impose judgment and penalties, but suspend enforcement thereof and place the licensee on probation;

(c) Suspend or limit his right to practice in this state for a period of time not exceeding five years;

(d) Revoke his license; which license may be reinstated by the board upon sufficient showing that an error was made as to evidence or to correct an injustice;

(e) Take such other action, in relation to disciplining him, as the board in its discretion may deem proper; and

(f) Withhold any license, when the same has not been delivered, either permanently or for a period of time.

(3) The board shall have the right and power in proper cases to grant rehearings on its own, or if applied for within thirty days, upon questions of fact determined by the board.

458.131 *Procedure for revocation, suspension, etc.*—

(1) Any person, including the board or any member thereof, may prefer charges against any licensee or applicant for license. Such charges shall be in writing and shall be sworn to by the person making them, when not made by the board as a body. They shall be preferred by delivering them, together with ten copies thereof, to the secretary of the board, who, forthwith, shall furnish each member of the board with a copy of said charges.

(2) All charges, unless dismissed by the board as being unfounded or trivial, shall be heard and disposed of by the board within four months after the date upon which they were preferred, except as to cases hereinafter noted.

(3) The time and place of said hearing shall be fixed by the board, and a copy of the charges, together with notice of the time and place of the hearing, shall be served upon the person against whom preferred, either personally or by registered mail with return receipt demanded, addressed to the said person at his last known address as the same appears on the records of the board, at least twenty days before the time fixed for the hearing.

(4) Where personal service cannot be made as aforesaid, or where registered notice is returned undelivered, the secretary of the board shall cause a short, simple notice to the licensee to be published for four consecutive weeks (four publications being sufficient) in a newspaper published in the county wherein the licensee's last known address appears as shown on the records of the board, or, if no newspaper be published in said county, then said notice may be published in a newspaper published in an adjoining county. If said address appears in some state, territory or country other than this state; then said notice may be published in Leon County.

(5) Said notices shall contain the name of the licensee, or applicant, his last known address, the serial number of his license, if any, under which he is authorized to practice in this state, the time of the preferring of the charges, the date set for the hearing of said charges, the nature of the charges, and the place where said hearing will be held.

(6) Due proof of service or of publication shall be filed with the secretary of the board and shall be recorded by him in the minutes of the board. The board, for good cause shown, may continue any hearing from time to time and in proper cases to a time beyond the aforesaid four months' period. At any hearing the accused shall have the right to appear personally and by counsel, to cross-examine witnesses appearing against him and to testify and produce witnesses in his defense.

(7) Notwithstanding any provision of this section, where charges preferred against a licensee involve any one of the offenses set forth in Section 458.13 (l) (a), (b), (d), (i) and (l) in the opinion of the president, vice president and secretary-treasurer, the evidence in support of the charges is clear, competent and unequivocal, the subject's license may be temporarily suspended by the board pending a full hearing as herein provided. Such suspension shall be without prejudice to the licensee at such full hearing.

458.132 *Conduct of hearing, witnesses, evidence, etc.*—

(1) For the purpose of such hearing, the board shall have the power, under the hand of the president, vice president or secretary, and the seal of the board, to require the production of books, papers or other documents and may issue subpoenas to compel the defendants or witnesses to testify and produce such books, papers or other documents in their possession as may be in the opinion of the board, relevant to any hearing before it; said subpoenas to be served by the sheriff of the county where the witness resides or may be found. Such witnesses shall be entitled to the same per diem and mileage as witnesses appearing in the circuit court of the state, which shall be paid by said board. Any member of the board may administer oaths or affirmation to witnesses appearing before the board. Subpoenas may be so issued for and in behalf of the defendant.

(2) If any person shall refuse to obey any subpoenas so issued or shall refuse to testify or produce any books, papers, or other documents required by the board, the board may present its petition to the circuit court of the county where any such person is served with the subpoena or where he resides, setting forth the facts, and shall deposit with said court, when such subpoena is issued in its behalf, the per diem and mileage to secure the attendance of such witness (the defendant may make like deposits), whereupon said court shall issue its rule nisi to such person requiring him to obey forthwith the subpoena issued by the board or show cause why he fails to obey the same, and unless the said person shows sufficient cause for failing to obey the said subpoena, the court shall forthwith direct such person to obey the same, and upon his refusal to comply, he shall be adjudged in contempt of court and shall be punished as the court may direct.

(3) If at such hearing the board shall be satisfied, from the evidence and proofs submitted, that the accused has been guilty of any of the charges mentioned in § 458.13 hereof it shall thereupon, without further notice, take such action upon the charges and impose such penalties as it may be advised under said § 458.13. The records of the board shall reflect the action of the board upon the charges.

(4) The board shall preserve a record of such proceedings in a similar manner as records in court proceedings are kept and preserved in the circuit courts of this state.

458.133 *Review of orders of the board by the circuit courts; procedure and venue.*—

(1) The final order of the board in such proceedings shall be subject to review by the circuit courts of Leon county, or of the county wherein the licensee has recorded his license and has his principal professional office or of the county wherein the books and records of the board are kept.

(2) All other orders of the board shall be subject to review in the same courts.

(3) All such reviews shall be obtained by filing a notice of appeal within sixty days from and after the

making of the order complained of. The said notice of appeal shall be filed with the secretary of the board and a copy of it with the clerk of the circuit court to which returnable. The provisions of Chapter 59, shall be applicable to such appeals insofar as the same may be applied. The original record of the board in the cause may be transmitted to the appellate court in accordance with sub-section (4) of § 59.27, in lieu of a transcript of record at the election of the appellant. The board shall not be liable for the cost of a transcript of record should one be used and the cause reversed by the appellate court.

(4) Any interested party may appeal from such orders of the circuit court in the same manner and with the same procedure as is provided by law for an appeal from final decrees of the circuit court in equity cases.

458.14 *Definition of practice of medicine; limitations, exceptions, etc.*—

(1) Any person, except as hereinafter provided, shall be deemed to be practicing medicine within the purview of this chapter, who holds himself out as being able to diagnose, treat, operate or prescribe for any human disease, pain, injury, deformity, mental or physical condition, or who shall offer or undertake, by any means or method, to diagnose, treat, operate, or prescribe for any human disease, pain, injury, deformity, mental or physical condition.

(2) This chapter shall not be construed as applying to:

(a) Any osteopath, chiropractor, chiropodist, naturopath, optometrist, nurse, pharmacist, dentist, or midwife, duly and legally licensed by their respective state boards, when practicing their profession within the purview of the statutes applicable to their respective professions.

(b) Any lawfully qualified physician, of some other state or country, when meeting legally registered and qualified physicians of this state in consultation.

(c) Any physician duly qualified to practice in any county of this state called to attend isolated cases in another county of this state, although not residing or habitually practicing in such other county.

(d) Any person furnishing medical assistance in case of an emergency.

(e) The domestic administration of recognized family remedies.

(f) The practice of the religious tenets of any church in this state.

(g) Any person or manufacturer who, without the use of drugs or medicine, mechanically fits or sells lenses, artificial eyes, limbs or other apparatus or appliances, or is engaged in the mechanical examination of eyes for the purpose of constructing or adjusting spectacles, eye-glasses or lenses.

(h) Commissioned medical officers of the armed forces of the United States, and of the public health service of the United States, while on active duty for the United States.

(i) Any person while actually serving, without salary or professional fees, on the resident medical staff of hospitals in this state; subject, however, to the limitations contained in subsection (3) hereof.

(j) Any person employed as a physician in a state institution providing such person is qualified for licensure in this state in all respects (except as to citizenship) and is working under the supervision of a licensed medical doctor; subject however to the limitations contained in subsection (3) hereof.

(3) Every person practicing as a resident physician, assistant resident physician or intern in any hospital in this state, shall register with the state board of medical examiners showing the date upon which he started to practice as aforesaid within this state. Every hospital employing a resident physician, assistant resident physician or intern shall, on January 1 and July 1 of each year, furnish the state board of medical examiners with a list of their said employees and such other information as the board may direct. Unless previously authorized by the board no person may be employed as a house physician or act as a resident physician, associate resident physician, or an intern in a hospital of this state or in any state institution without a license. Any person violating this subsection shall be deemed guilty of a misdemeanor.

458.15 *Sign at entrance of office to show branch of medical or healing art practiced; penalty.*—

(1) Every person licensed under the laws of the state to practice medicine, surgery, osteopathic medicine, chiropractic, naturopathy, chiropody, podiatry or any other kind or branch of the medical or material healing art, whenever actively engaged in the practice of same, or whenever holding himself out as a practitioner of same, shall cause to be placed and kept in a conspicuous place at each entrance to his office or usual place of business, words or proper abbreviations, in intelligible lettering not less than two inches in height and one inch in width clearly denoting the particular kind or branch of the medical or material healing art he is licensed to practice under the laws of the state.

(2) Any person convicted of violating subsection (1) of this section shall be punished by a fine of not more than one hundred dollars or by imprisonment in the county jail for a period of not more than six months.

458.16 *Specific acts as violations of chapter and penalties therefor.*—

(1) It shall be unlawful for any person to:

(a) Sell or fraudulently obtain or furnish any medical diploma, license, record or registration, or aid or abet in the same; or

(b) Practice medicine under cover of any diploma, license, record or registration illegally or fraudulently obtained or secured, or issued unlawfully on fraudulent representation; or

(c) Advertise to practice medicine under a name other than his own or under an assumed name; or

(d) Falsely impersonate another practitioner of a like or different name;

And such act shall constitute a felony for which any person upon conviction shall be punished by a fine of not more that one thousand dollars or by imprisonment in the state prison for not more than five years.

(2) It shall be unlawful for any person not holding a lawfully issued license then in full force and effect, authorizing him to practice medicine to:

(a) Practice or advertise to practice medicine.

(b) Use in connection with his name any designation tending to imply or designate him as a practitioner of medicine;

(c) Use the title "doctor" or any abbreviation thereof in connection with his name, or with any trade name in the conduct of any occupation or profession, involving or pertaining to the public health, or the diagnosis or treatment of any human disease, pain, injury, deformity or physical condition unless duly licensed by a board created under the laws of the state; and such act shall constitute a felony for which any person upon conviction shall be punished by a fine of not more than one thousand dollars or by imprisonment in the state prison for not more than five years.

458.17 *Mental or physical examinations by doctors or other practitioners of healing sciences; copies of reports to be furnished.*—

Any doctor or other practitioner of any of the healing sciences making a physical or mental examination of, or administering treatment to any person, shall upon request of such person, his guardian, curator or personal representative in the event of his death, furnish copies of all reports made of such examination or treatment. Such reports shall not be furnished to any person other than the patient, his guardian, curator, or personal representative, except upon the written authorization of the patient; provided, however, that nothing herein shall prevent the furnishing of such reports without such written authorization, to any person, firm or corporation who with the patient's consent shall have procured or furnished such examination or treatment, and where compulsory physical examination is made pursuant to §

768.09, or court rule copies of the medical report shall be furnished both the defendant and the plaintiff.

458.18 *Short title.*—

This act may be cited as the Medical Practice Act.

Section 2. *Transitory Provisions.*—

(1) Every license, permit, or order of the Board in force immediately prior to the effective date of this law and existing or issued under any law herein repealed is valid until its original expiration date, if any, unless earlier terminated, revoked or suspended in accordance with the provisions of this law.

(2) All rules and regulations adopted by the board and in effect immediately prior to the effective date of this law, which are not in direct conflict with any provision of this law, shall remain in full force and effect unless and until repealed, modified or amended by the board.

(3) All persons who were members of the state board of medical examiners immediately prior to the effective date of this act shall serve as members of the board provided for herein until the expiration of the term to which each such person was appointed.

(4) This act shall not impair or affect any act done, offense committed or right accruing, accrued, or acquired or liability, penalty, forfeiture or punishment incurred prior to the time this act takes effect, but the same may be enjoyed, asserted, enforced, prosecuted or inflicted, as fully and to the same extent as if this act had not been passed.

Section 3. *Repeals.*—

All sections of Chapter 458, Florida Statutes, 1959, except those sections hereinafter set forth, are hereby repealed. Sections 458.081, 458.082, 458.083, 458.084, 458.085, and 458.086 are expressly not repealed, however, the statutory revision department of the attorney general's office is directed to transfer these sections to a chapter relating to the state board of health and to renumber such sections accordingly.

Section 4. *Severability clause.*—

It is the intent of the legislature that if any section, subsection, paragraph, sentence, clause or provision of this act is held invalid, the remainder of this act shall not be affected.

Section 5. *Effective date.*—

This act shall take effect immediately upon becoming a law.

Supplement 1

H. PHILLIP HAMPTON

Since publication of the delegates' handbook, significant activity has occurred concerning the Florida Plan for Care of the Needy Sick and Aged described in the first part of this committee's annual report.

In March members of the Florida Medical Association visited the Florida Congressional Delegation in Washington and found great interest in the problem of medical and hospital care for the aged and needy sick of this country. (Witness recent newspaper and television coverage.) The members of Congress from Florida, notably Representative Syd Herlong (a member of the House Ways and Means Committee) were in agreement with us in opposition to increasing social security tax to provide hospital medical care for all social security recipients regardless of the recipient's ability to pay for it himself. Such present legislation before the Congress would provide federal government payment for millions of citizens who can afford to pay for this service themselves and would not provide such care for the millions of needy sick who are not social security recipients.

The members of Congress were anxious to know more of the Florida Plan for the Care of the Needy Sick and requested a brief resume of this plan and our experience, which was supplied them.

Senator Smathers subsequently requested your present chairman and the new chairman of the Legislative Committee, Dr. Ed Annis, to meet with him in Washington Tuesday of this week to discuss federal legislation to aid the states in developing their individual programs for medical care of the needy sick.

We have conferred at length with Senator Smathers who has a keen interest in this pressing problem and is being urged by strong leaders in Congress to assume leadership for the enactment of such laws by this session of Congress.

The Trustees of the A. M. A. yesterday passed the following resolution: "In accordance with the previously stated policy of the House of Delegates, it is the opinion of the Board of Trustees that the A. M. A. could support a public assistance program to cover those citizens who, on the basis of local determination, are considered indigent for the purpose of receiving health care benefits."

The Board of Governors of the Florida Medical Association passed a resolution last evening concerning these problems which will be presented to you in its supplemental report.

Supplement 2

EDWARD R. ANNIS

I have been asked to report to you on a continuation of the program that your Committee on Legislation and Public Policy has been asked to carry out in Tallahassee next year.

We have two main recommendations:

1. Revisions to the Medical Practice Act, and
2. We plan, if the climate is right, to propose a nursing home care program.

We will also work on other legislative items recommended by your Committee, such as coordinated single purchasing for the state.

I know that many Florida doctors are supporting various candidates and I want to commend those doctors who are doing so. I am glad that we have so many good candidates this year and want to remind you once again that the way in which you can be most helpful is by giving your full support in every way to the candidate of your choice.

Dr. Cullipher: "We recommend acceptance of the report of the Committee on Mental Health, by Dr. William M. C. Wilhoit, Chairman, as published in the Handbook.

"Mr. President, I move the adoption of this portion of the report."

Motion seconded and carried.

Report of Committee on Mental Health

WILLIAM M. C. WILHOIT, *Chairman*

During the past year, the Committee has held four official meetings: May 3, Sept. 18 and Nov. 8, 1959, and Jan. 24, 1960. On September 18, the Committee co-sponsored, along with the Florida Association for Mental Health and the Council on Research and Training in Mental Health, a seminar on aging in Sarasota which was attended by prominent persons in the fields of aging and mental health. The annual state mental health conference was held Nov. 8, 1959, in Jacksonville.

Among the varied subjects discussed and acted upon by the Committee were an evaluation and revision of the Association's mental health program, the practice of psychotherapy by psychologists, a study of sexual psychopathy laws, the state welfare vendor drug program as applied to psychiatric patients and the establishment of liaison between the Association and the state mental hospitals.

Considerable emphasis was placed upon the annual mental health conference, which has been one of the Committee's major activities. The 1959 conference was attended by some twenty invited key leaders in the field

of mental health throughout the state, including members of the legislature, state agencies, medical schools and voluntary groups. We feel that the mutual exchange of ideas and programs as accomplished at the conference is highly beneficial to the people of Florida and we recommend that these conferences be continued.

Recognizing a need for liaison between the Association and the state mental hospitals, the Committee established what is hoped will become a continuing program in which each member of the Committee periodically visits the hospital nearest his area and maintains contact with the staff.

As a result of our initial field survey carried out in each of the state mental hospitals, the Committee recommends that:

(1) Patients who are committed voluntarily to the state hospitals be required to submit ten days written notice of their desire to be discharged.

(2) A psychiatric evaluation and screening facility be established at the earliest possible time at the state prison at Raiford.

(3) Utilizing such funds as may be available, provision be made for establishing salary incentives for continuous service by staff members in state hospitals and for attracting additional qualified personnel.

(4) The individual state hospital superintendents be authorized at their discretion to encourage and permit professional staff members to attend at least one scientific postgraduate meeting per year.

(5) Physicians or referring agencies be required to furnish to the superintendent of the state mental hospital a history of essential facts concerning the mental illness of a candidate for admission and that the prospective patient's transfer to the state hospital be contingent upon the submission of such information either in advance or accompanying the patient. It is suggested that consideration be given to revising existing forms to include this information.

(6) The use of so-called tranquilizing drugs be recognized as saving funds by reducing the hospital stay of many mental patients. It is further recommended that these drugs be made available to indigents and that their indiscriminate use be deplored.

(7) The problem of geriatric patients and those with character disorders in state hospitals be recognized and studied for future attention and action.

(8) The establishment of a facility for psychotic children as previously recommended by the legislature be endorsed but the proposed location be re-examined in order that the unit be located closer geographically to the teaching center of the University of Miami School of Medicine.

I would like to express my appreciation to the members of the Committee, Drs. Sullivan G. Bedell, Bernard Goodman, Zack Russ Jr. and Mason Trupp, for their willingness to assist whenever called upon during the year.

Dr. Cullipher: "We recommend acceptance of the Report of Committee on State Controlled Medical Institutions, by Dr. William D. Rogers, Chairman, as published in the Handbook.

"Mr. President, I move the adoption of this portion of the report."

Motion was seconded and carried.

Report of Committee on State Controlled Medical Institutions

WILLIAM D. ROGERS, *Chairman*

As chairman of the Committee on State Controlled Medical Institutions, I wish to submit the following report:

Alcoholic Rehabilitation Program

During 1959 the Florida Alcoholic Rehabilitation Program has continued to carry out its three main functions: treatment, education and research.

Alcoholism is generally viewed by the program as a socio-medical condition of an addictive type characterized by a describable progression of symptoms and usually associated with other psychiatric difficulties. The condition is regarded as sufficiently widespread and complex in its involvements as to require a specialized program which integrates activities and disciplines in a unitary approach, the objectives of which are control and prevention of the condition.

Clinical services covering diagnosis, treatment, rehabilitation and referral, offered through four outpatient clinics located in Miami, Jacksonville, Tampa and Pensacola, and a 50 bed inpatient facility in Avon Park, were increased this year by the opening of a special alcoholism clinic in the Department of Psychiatry, College of Medicine, University of Florida, Gainesville. A grant of $12,500 was made by the Program to the Department for this purpose.

The clinical services, limited to the ambulatory treatment of alcoholism, are directed by psychiatrists. Each clinic is staffed by fulltime psychiatric social workers, parttime internists and psychologists; and fulltime clerical personnel. Since the opening of the clinics in 1955, 2,423 individuals have been registered in the clinics, of which 579 were registered in 1959.

During 1959 cooperative plans were made with the Sarasota County Public Health Department for a special alcoholism treatment service, which will be made a part of the regular activity of that department.

The Alcoholic Rehabilitation Center in Avon Park, which opened in December 1956, has admitted 1,680 patients. Of this number, there were 611 new admissions and readmissions in 1959. Readmissions are 12% of the total.

The Center provides medical care, psychiatric social work, and psychotherapy as a part of the rehabilitation of alcoholics. Twenty-eight days is the maximum period of hospitalization. Readmissions are permitted for carefully selected patients.

The state administrative offices of the program are also housed in the Center.

Division of Child Training

The Sunland Training Center at Gainesville, an institution designed and equipped for the care of the mentally retarded and patients suffering from convulsive disorders, has continued to expand and develop its program during the past year. As of December 1959 the population was 1,847.

The professional staff has been increased during the year, as well as additional housing facilities. New facilities, such as diagnostic for the x-ray and electro-encephalograph equipment, and physical therapy equipment, have been added. A Federal grant has been approved, and with state matched funds a research department is planned for this institution; and plans are under way for additional facilities to house this program.

The Sunland Training Center has continued its affiliation with the University of Florida during the year, and many forward steps have been taken in rehabilitation. One of the more significant ones was two Half-Way Houses, with accommodations for about fourteen patients each. Patients qualifying for these Half-Way Houses are

given employment opportunities through Vocational Counselors in the Gainesville area. The purpose of the Half-Way House is to provide as near normal living outside an institution as possible to rehabilitate and prepare the patient to take his place in society.

During the past year the Central Florida Tuberculosis Hospital at Orlando was closed for the treatment of tuberculosis and the Division of Child Training has been in the process of converting this facility to the care of the non ambulatory type, mentally retarded patient. Just recently the first patients were moved to this facility from the Sunland Training Center at Gainesville. Eventually they plan to house between 500 and 600 patients at this facility. Also the Division of Child Training has a new institution near Fort Myers, which is known as the Sunland Training Center at Fort Myers. This institution will be opened during the late Spring or early summer of 1960. The initial construction will provide facilities for 800 additional patients. This will relieve the waiting list to a great extent, since at the present time there are between 1,100 and 1,200 on the waiting list.

Division of Mental Health

This Division has as its responsibility the four state hospitals for the care of psychotic disorders, the Florida State Hospital, Chattahoochee; the G. Pierce Wood Memorial Hospital, Arcadia; the South Florida State Hospital, Hollywood; and the Northeast Florida State Hospital, Macclenny.

The Northeast Florida State Hospital at Macclenny is a completely new facility consisting of 500 beds. This hospital was equipped, staffed and opened in August of 1959, and has been receiving patients from that general area since its opening.

Throughout the four state hospitals there has been definite progress made in the discharge rate of patients, as well as shortening of the stay of patients. The Florida State Hospital at Chattahoochee and the G. Pierce Wood Memorial Hospital at Arcadia have actually shown a slight decrease in their operation.

There has been much emphasis on in-service training programs for new employees, as well as carrying on psychiatric affiliation in nursing education, operating schools of nursing education at the Florida State Hospital at Chattahoochee, and the South Florida State Hospital at Hollywood. Also several research programs have been started during the year at the South Florida State Hospital, Hollywood, as well as continuing their program of resident training in affiliation with the Psychiatric Institute in Miami.

The home placement program for patients has been further expanded, and the follow-up care of patients placed on trial visit with the State Board of Health has been most effective, and has decreased the number of patients returning to the institution while on trial visit.

The number of new admissions admitted to our State Hospitals is reflected in the state population growth, and this number continues to grow. They are expecting 4,500 admissions during the fiscal year, 1959-60.

No facilities have yet been provided in this Division for the treatment of severely emotionally disturbed or psychotic children. A legislative request was made to finance this program during the last session of the Legislature but there were insufficient funds in the treasury to finance this program, however, plans are being made to present a similar request to the next session of the Legislature. At this time it is definitely felt that a 50-bed facility for psychotic children is badly needed. There are further plans under way to expand research programs, follow-up care of patients released, and for out patient services located at the individual hospitals.

The mental hospitals have had to maintain during the year a waiting list of patients to enter the state hospitals, but this waiting list has consisted mostly of the aged patient. Several changes were made in the commitment laws during the legislative session of 1959, and in addition to our regular commitment, and the voluntary admission procedure, which was already in effect, a new certification procedure was passed into law; also an automatic restoration of judicial sanity law was passed, serving patients who were declared competent by the staffs of the hospitals.

As of Dec. 31, 1959 we had 9,200 patients under treatment in the four state mental hospitals.

Dr. Cullipher: "We recommend acceptance of the Report of the Committee on Poliomyelitis Medical Advisory, Dr. Richard G. Skinner Jr., Chairman, as published in the Handbook.

"Mr. President, I move the adoption of this portion of the report."

Motion was seconded and carried.

Report of Poliomyelitis Medical Advisory Committee

RICHARD G. SKINNER JR., *Chairman*

Representatives of this Committee attended the meeting with the Dade County Public Health Service and other interested persons in regards to the oral polio field trials to take place in Dade County this spring. After due deliberation and careful consideration of all angles involved, it was decided that the field trials should take place. They have the full cooperation and support of the Dade County Medical Association, the Dade County Health Department, and the University of Miami. This was subsequently presented to the Board of Governors of the Florida Medical Association and has received their approval. Efforts will be made to administer the oral polio vaccine of the Cox strain to as many people in Dade County as is feasible and possible, with the idea to saturate the community.

The problem of the frequency with which the Salk vaccine should be given is still with us. It is still the considered opinion of the authorities involved that the vaccine should be given in the following method: the first two injections should be given one month apart, and the third injection seven to 12 months after the second. These may be given coincidentally with the DPT injections in smaller children. After the initial series is completed, no more than two years should elapse before a booster is given, and subsequent boosters should be given at two year intervals. There will be some variations among the physicians as to when they give these boosters. In places of increased incidence or possible epidemics, the booster should certainly be given at yearly intervals. There is some evidence that babies of mothers who have been actively immunized with the Salk vaccine during the pregnancy should not receive Salk vaccine until they are three months old, as a passive antibody is transferred from the mother's blood and will interfere with active immunization in the infant.

Dr. Cullipher: "We recommend accepting the report of the Delegates to the American Medical Association.

"Mr. President, I move the adoption of this portion of the report."

Motion was seconded and carried.

Report of Delegates to American Medical Association

R. B. Chrisman Jr., M.D., Chairman
Francis T. Holland, M.D.
Meredith Mallory, M.D.
Burns A. Dobbins Jr., M.D.

A complete summary of the June and December 1959 meetings of the American Medical Association will be

found in the August and February issues of The Journal of the Florida Medical Association. A summary of both meetings was also provided every physician in "The AMA News."

The Florida resolution regarding tetanus immunization was adopted by the House of Delegates of the A.M.A. and its principles are being implemented throughout the nation.

Your delegates selected Dr. Reuben B. Chrisman Jr., to serve as chairman of the delegation for the year 1959-60.

The 1960 annual meeting of the A.M.A. will be held in Florida at Miami Beach on June 13-17, with our own Dr. Louis M. Orr serving as President. Every physician is urged to attend this meeting.

Dr. Cullipher: "The report of the Board of Medical Examiners, by Dr. Homer L. Pearson Jr., is approved as read.

"Mr. President, I move the adoption of this portion of the report."

Motion was seconded and carried.

Report to: Florida Medical Association
House of Delegates

From: Florida State Board of Medical Examiners
Homer L. Pearson Jr., M.D., Secretary

During 1959 we examined for licensure 661 applicants, 561 received licenses, and approximately 15 per cent failed. We held eleven hearings on narcotic violations which resulted in two licenses being revoked, two licenses suspended, five licenses suspended with the suspension not enforced and the physicians placed on probation with no narcotic privileges; one physician reprimanded with the recommendation that he not have narcotic privileges; and one charge dismissed with the recommendation that the physician not have narcotic privileges. A hearing on the charge of unprofessional conduct was dismissed.

In the past five years we have examined 3,323 applicants and licensed 2,640. The years 1956 and 1957 were the heaviest but as you can see from the following figures there has not been a marked trend in either direction. In 1955, 619 were examined and 499 licensed; in 1956, 723 were examined and 544 licensed; in 1957, 745 were examined and 575 licensed; in 1958, 575 were examined and 461 licensed.

As requested by the House of Delegates we have been studying the Medical Practice Act with the idea of making certain changes. During the year we met with your Legislative Committee and they will present our recommendations to you at this meeting.

I will not discuss this matter in detail but want to say that the principal changes will be in regard to the disciplinary measures to be taken by the Board. At this meeting the House of Delegates will select members to the Disciplinary Committee who will work with the Board of Medical Examiners in a more active policing of the medical profession. We feel that it is much better to police our own than to have outsiders attempting to police us. In order for us to do our own policing it will be necessary to have additional funds and one of the proposed changes in the Medical Practice Act is that every physician holding a Florida license will be required to register annually with the Board of Medical Examiners and the registration fee will be $10. You are urged to approve this recommendation for without it we cannot set up the organization to assume the added duties that policing the profession would require.

In 1959 the Division of Physical Therapy of the Board of Medical Examiners registered 42 physical therapists through endorsement and seven through examination. There are now 291 physical therapists registered to practice in Florida.

Dr. Cullipher: "We recommend acceptance of both the supplemental reports of the Board of Governors, the resolution regarding H.R. 4700 and the report on Care of the Needy Sick and Aged.

"Mr. President, I move the adoption of this portion of the report."

Motion was seconded and carried.

Supplemental Reports of Board of Governors

1

Resolution

WHEREAS, the Congress of the United States has for several sessions through the Ways and Means Committee of its House of Representatives, considered H.R. 4700 (the so-called Forand Bill), and

WHEREAS, the Ways and Means Committee has more recently, in this 86th Congress, spent long and arduous hours listening to testimony in a democratic fashion from individuals and organizations interested in the problems of the aging, and

WHEREAS, the physicians of this nation, together with many other lay organizations and individuals, feel that the above legislation is "socialized medicine" for a segment of our population, with an ever increasing cost to all citizens, and

WHEREAS, these groups and individuals feel that political medicine would hinder rather than help the aging population healthwise, and

WHEREAS, it is the desire of this Association and physicians everywhere to better the health care of this group as well as that of all Americans, and

WHEREAS, it is felt that such programs can best be obtained and maintained through a voluntary system which would not destroy the valuable doctor-patient relationship, and

WHEREAS, the members of the medical profession, along with other groups, are continuing to explore and study methods for better health care of the aging and all other citizens, and

WHEREAS, the House Ways and Means Committee by majority vote of 17-8 on March 29, 1960, did disapprove the Forand Bill, and

WHEREAS, the Administration and individual members of Congress have expressed opposition to same,

NOW THEREFORE BE IT RESOLVED, that this House of Delegates of the Florida Medical Association, meeting in annual session in Jacksonville, Florida, this 8th day of April, 1960, go on record as commending those members of the House Ways and Means Committee, the Administration and others who so forthrightly spoke out in opposition to H.R. 4700, and

BE IT FURTHER RESOLVED, that the Florida Medical Association express its admiration, appreciation and commendation to the above groups and individuals for their courage, their interest and their foresight in behalf of all people concerned with this problem, and

BE IT FURTHER RESOLVED, that a copy of this Resolution be sent to the President of the United States, to the Vice President of the United States, to the Speaker of the House of Representatives, to the members of the House Ways and Means Committee, to the Secretary of Health, Education and Welfare, to the Honorable members of the Florida Congressional Delegation, to the Board of Trustees of the American Medical Association and to all state medical associations.

2

The Florida Plan for Care of the Aged and Needy Sick

Florida has made rapid progress during the last decade in establishing a program to provide hospital and

medical care for the needy sick of all ages. In Florida no one who requires hospital medical care need go without it. The medical doctors of Florida reaffirm the traditional principles of the medical profession to provide medical care for all—including the aged and the needy sick.

A state and county matching fund to pay hospitals the cost of care to the needy sick was established by the Legislature in 1955. This plan is based upon the results of studies initiated by the medical doctors of Florida in 1950 and made by committees appointed by the Governor.

The major financial and administrative responsibility for this service remains with the local government and participation by the individual counties is voluntary (98%).

Federal matching funds have been used in hospitalization of public assistance recipients who qualify in the four welfare categories eligible for federal assistance but they comprise less than 50% of those given hospital medical care through this program.

During this biennium ten million dollars is being spent in Florida through this program to pay hospitals the cost of hospital care for the needy sick at an average daily cost of $22 for an average hospital stay of almost 9 days. In addition, state hospitals provide care for tuberculosis and long term mental illness.

In order to provide more complete medical care to the needy sick, the Hospital Service Law was amended in 1959 to include outpatient care and ancillary nursing and medical home services. Sufficient funds are not yet available to fully implement this program but we are making progress and will continue to do so as long as the responsibility for this service remains with the state and local governments.

For any medical service program to be economically effective, the practicing medical profession must have a responsible position in planning and management. The doctors of Florida have demonstrated their ability to assume this responsibility and have formed the Florida Medical Foundation for that purpose.

Federal matching funds now available to states for medical service to welfare recipients are too restrictive by regulation and thereby discourage the states in developing their individual programs for medical care of the needy sick.

Funds for medical and hospital care should be administered separately from welfare subsistence funds, permit voluntary county matching with state and federal funds, and should not be appropriated for specific welfare categories.

Good, economical, and effective medical care could be provided for the aged and needy sick of all ages by individual state plans and we believe this is primarily a state and community responsibility.

If the Congress deems it advisable, such state plans could be encouraged by federal matching funds provided three fundamental changes are made in regulations concerning the use of federal matching funds in state medical care programs.

1. Federal matching funds for a state medical care program should not be limited to categories of the needy sick, such as the blind or aged, but should be available to be used in providing medical, hospital and nursing home care and drugs for all those in need of care as locally determined without the means of providing it for themselves.
2. Federal matching funds for state medical care programs for the needy sick should be appropriated and administered at the federal and state levels separate from funds used for subsistence programs. The practicing medical profession should have a responsible position in planning and management of those medical programs which can best be done through state agencies under medical direction.
3. The local or county governments should be permitted to voluntarily participate in the matching fund program to provide medical care for the needy sick just as states may voluntarily participate in the federal matching program, thus encouraging community interest and responsibility in providing this care.

In this manner states will be encouraged to develop their individual programs for hospital and medical care of the needy sick which will be more effective and economical than any single national program. Together with the voluntary health insurance plans for those who can provide for themselves, good medical care will be made available to everyone.

Dr. Cullipher: "We recommend disapproval of the resolution on Admission to Veterans' Hospitals submitted by Dade County Medical Association. We do agree to the basic philosophy expressed in this resolution and recommend that our delegates to the American Medical Association continue their cooperation in this matter with the A. M. A. Committee on Federal Medical Services.

"I might give you a word of explanation here that certainly we all are for that resolution, however, we had been advised by Joe Stetler on the day before the Committee hearing that this is already before the Committee on Federal Medical Services and will be reported out of the A. M. A. House of Delegates either in June or at their Fall meeting. They feel that such a resolution at this time might be more of a handicap than a help and have suggested it might be well to postpone it, in other words, to leave it to their discretion.

"Mr. President, I move that this portion of the report not be approved and not be published in The Journal."

Motion was seconded and carried.

Dr. Cullipher: "The Committee recommends approval of the resolution on merger of state agencies, by the Dade County Medical Association, as published in the Handbook.

"Mr. President, I move the adoption of this portion of the report."

Motion was seconded and carried.

Resolution

Merger of State Agencies

WHEREAS, the Florida Legislative Council of the Senate and House has under study a proposal to merge the State Board of Health and the State Department of Public Welfare; and

WHEREAS, several members of the Florida Legislature indicated, through the press, that they are seriously considering and/or are possibly in favor of such a merger; and

WHEREAS, such a merger might eventually mean the creation of a position of Secretary of Health and Welfare which would become an elective office and therefore a political office;

WHEREAS, the proposed merger would not be in the best interest of the citizens of the State of Florida prin-

cipally because the State Board of Health activities should be wholly a medically directed agency and, due to the importance of both programs, neither should be involved politically; and

WHEREAS, both agencies have been historically and are, at present, under control of the Merit System and, therefore, outside the realm of politics; and

WHEREAS, the present efficient program activities of the State Board of Health and the State Department of Public Welfare consist of separate and essentially different functions; and

WHEREAS, no useful purpose would be served by such a merger as no economics or efficiency would be gained by the addition of a top-heavy bureaucracy.

NOW THEREFORE BE IT RESOLVED that the Dade County Medical Association, Miami, Florida, on behalf of its members vigorously condemn and oppose the proposed merger of the State Board of Health and the State Department of Public Welfare.

BE IT FURTHER RESOLVED that the House of Delegates of the Florida Medical Association at its annual meeting be urged to adopt a similar resolution.

Presented by
DeWitt C. Daughtry, Secretary
Dade County Medical Association

Dr. Cullipher: "We recommend disapproval of the resolution on House Bill 312 (Aid to Dependent Children) by the Collier County Medical Society. It was our feeling that this was primarily a welfare province even though it is of critical interest to us and that perhaps we should not intrude into other agencies' business.

"Mr. President, I move that this portion of the report not be approved and not be published in The Journal."

Motion was seconded and carried.

Dr. Cullipher: "Regarding the resolution on revisions to the Medical Practice Act presented by Broward County Medical Association, your Committee recommends approval of No. 1 and disapproval of No. 2.

"Mr. President, I move the adoption of this portion of the report as amended."

Motion was seconded and carried.

Resolution

Revisions to Medical Practice Act

WHEREAS, the Committee on Legislation and Public Policy of the Florida Medical Association has approved, for presentation to the House of Delegates of the Florida Medical Association, certain proposed revisions to the Medical Practice Act (Florida Statutes, Chapter 458); and

WHEREAS, certain of the proposed revisions are of particular interest to this Association, namely:

1. Provisions that registration [for renewal of licenses to practice medicine] shall be with the Board of Medical Examiners (in lieu of the State Board of Health) and the registration fee increased from $1.00 to $10.00; and

WHEREAS, this Association believes that the incorporation of these proposed revisions in the Medical Practice Act would be to the best interests of the Florida Medical Association and this Association;

NOW, THEREFORE, BE IT RESOLVED that the foregoing enumerated proposed revisions to the Medical Practice Act be, and they are hereby, endorsed for approval and subsequent legislative enactment, including such legislative changes and details as may be necessary to properly bring into effect the revisions set forth above.

It is hereby CERTIFIED that the foregoing is a true and correct copy of a Resolution of the BROWARD COUNTY MEDICAL ASSOCIATION, adopted on the 31 day of March, 1960, at a meeting duly called, held and convened, a quorum being present and voting thereon; that said resolution has not been altered, amended or repealed and is now in full force and effect.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the seal of said Association.

Presented by
Broward County Medical Association

Dr. Cullipher: "We recommend that the resolution on involuntary hospitalization for mental cases, from the Volusia County Medical Society, be referred to the Committee on Mental Health.

"Mr. President, I move the adoption of this portion of the report."

Motion was seconded and carried.

Resolution

Involuntary Hospitalization for Mental Cases

It being generally recognized by our profession that there exists pressing need of revision of the State Laws providing for the involuntary hospitalization of mental cases for diagnosis and treatment, particularly those mental cases constituting emergency cases, and that present statutes are becoming increasingly outmoded and inadequated in these instances, be it therefore herewith resolved that the Volusia County Medical Society go on record as recognizing the need of the following changes in our State Law, and herewith bring this matter to the attention of the Florida State Medical Society for appropriate consideration and action:—

1. Legislative provision for TEMPORARY EMERGENCY certification and involuntary restraint in hospital for diagnosis and treatment of a mental case by a local physician or physicians pending later formal judicial action in such case.
   It is believed such a provision would obviate the not infrequent problem presented where a physician treating a mental case which requires prompt, involuntary hospital care must, in the absence of immediately available County or other Judge with authority, rely upon the discretion of a usually unenthusiastic Sheriff's or Police Department to effect proper disposition of the case pending formal judicial inquiry and decision.
2. Further modification of present INCOMPETENCY laws to permit a separate action of judicial certification of a mental case for involuntary restraint, diagnosis and treatment in hospital, where circumstances indicate this to be sufficient, and whereby such action a so certified patient upon remission of his disorder sufficient in the judgment of physicians charged with his care to warrant his return to society may so return with automatic reinstatement of his rights and privileges held prior to his certification.
   It is believed this action would obviate the time consuming, expensive, often very frustrating, legal actions presently necessary in all incompetency cases, particularly those of short clinical duration where one occasionally observes more time spent in getting a patient adjudged incompetent and then, upon remission, in re-establishing his competency

so that he may go about making his living, than was spent in the treatment of his disorder.

3. This Society is well aware that legislation to effect the above needed changes necessarily entails ancillary legislation to protect society, participating physicians and the patient. It will be necessary to establish clear qualifications and perhaps registration of physicians charged with the responsibility and privilege of certification. Hospitals for such patient reception will perhaps require licensing and inspection laws formulated. However, it is believed that the experience of other states where it has been amply demonstrated such provisions work safely and expeditiously warrants the support of organized medicine towards such a goal of remedial legislation in our own State of Florida where the need is keeping pace with our rapidly increasing population.

Presented by
Volusia County Medical Society

Dr. Cullipher: "We recommend acceptance of the resolution on emergency medical care by the Dade County Medical Association, regarding liability in emergencies.

"Mr. President, I move the adoption of this portion of the report."

Motion was seconded and carried.

Resolution

Emergency Medical Care

WHEREAS physicians have been held liable for emergency medical care rendered in good faith at the scene of an emergency, and

WHEREAS such possible liability may deter some physicians from stopping to render medical care at the scene of an emergency and

WHEREAS several states have enacted legislation to protect physicians from liability for care rendered at the scene of an emergency; now therefore

BE IT RESOLVED that the Florida Medical Association shall at the next session of the state legislature, seek and support the enactment of legislation which provides that no person licensed under the Florida Medical Practice Act, who in good faith renders emergency care at the scene of the emergency, shall be liable for any civil damages as a result of any acts or omissions by such person in rendering the emergency care.

Presented by
Dade County Medical Association

Dr. Cullipher: "I wish to again thank all the members of my committee and move the adoption of this entire report as amended."

Motion was seconded.

Dr. George W. Morse of Escambia: "I would like to move that we reconsider the action on admission to veterans' hospitals and table it."

Dr. Morse's motion to reconsider this action was seconded and carried.

Dr. Walter W. Sackett Jr., of Dade, moved that this action be tabled. Motion was duly seconded and carried.

Dr. Cullipher's motion to adopt his entire report as amended was carried.

Dr. Jack: "Delegates, at this moment I wish to call to your attention that you have just adopted a change in the by-laws regarding the Committee on Membership and Discipline. It is now necessary for us to elect the members of this committee. The names of nominees for this extremely important committee, will be found on page 34 of your Handbooks. These nominations, from which two are to be elected from each congressional district, were made by the Board of Governors. The Chair will now entertain any additional nominations from the floor."

Dr. Francis H. Langley of Pinellas: "My name has been placed in nomination from District 1. In view of the fact that I will be serving as Chairman of the State Grievance Committee and so will be on the Judicial Council for the ensuing year, I feel it much better to withdraw my name from the list."

Dr. Jack: "Thank you, Dr. Langley. If there are no additional nominations, I will declare nominations closed. I would like to appoint Dr. Robert E. Zellner, Dr. George W. Morse and Dr. John T. Stage as tellers. Ballots will be passed out."

Dr. Walter C. Jones of Dade: "I would greatly prefer that some other man from my district have this. I would ask that, because of other commitments I have in the next few years, you permit me to withdraw my name from the list."

Dr. Jack: "In view of Dr. Jones' withdrawal, although the Chair declared nominations closed, he will reopen them for further nominations for the term ending in 1961 from District 4. If there are no further nominations, then the Chair again declares nominations closed. Please mark your ballots with the number of each congressional district, one to eight, and vote for either nos. 1 or 2, and 3 or 4, from each district.

"The Chair will now recognize Dr. H. Phillip Hampton."

Dr. Hampton: "I would like to offer an emergency resolution, made necessary by the fact that the occasion commemorated happened since the first meeting of the House."

Dr. Cecil M. Peek of Palm Beach moved that the rules be suspended so that this resolution could be acted upon without being referred to a reference committee. Motion was seconded and carried.

Dr. Hampton read the following resolution and his motion that it be accepted was duly seconded and carried.

Resolution

Commendation to Congressman Thomas B. Curtis

WHEREAS, Congressman Thomas B. Curtis of Missouri has, during his years in Congress, demonstrated a diligent pursuance of the truth, particularly concerning the economics of social security,

WHEREAS, he is eternally vigilant in the defense of individual freedom,

WHEREAS, he has exhibited a keen insight into the problems and deep concern for the welfare of the aged and needy sick,

WHEREAS, he has so ably presented the facts and principles of current administrative problems in health care in an address at the annual meeting of the Florida Medical Association on April 9, 1960,

NOW THEREFORE, be it resolved that the House of Delegates of the Florida Medical Association commend Congressman Curtis for his profound understanding and earnest efforts to provide real aid for the aged and needy sick without sacrificing our individual freedoms and wish him long life and opportunity to pursue these principles with which we sincerely concur.

Presented by
H. Phillip Hampton, M.D.
Hillsborough County Medical Association

Dr. Jack: "Delegates, our next order of business is one of our most important. The Chair will now call for nominations for officers, the first officer we will elect will be President-Elect. I will recognize Dr. John D. Milton."

Dr. Milton: "Mr. President, members of the House, distinguished guests, ladies and gentlemen. Nothing gives me greater pleasure than appearing before you to nominate a man for president-elect, a man whom all of you know and respect. He needs no flowery speech but certainly there are accomplishments that all should know.

"This man was born in Arabi, Georgia, on January 6, 1902. He attended elementary school in Arabi and the Emory Academy at Oxford, Georgia. Enrolling in the School of Liberal Arts at Emory in 1918, he graduated with an A.B. degree in the class with our own Louis M. Orr, President of the A.M.A. and Warren W. Quillian, Past President of the American Academy of Pediatrics. Like many, he had to interrupt his schooling for four years to recover and recoup his finances, by such activities as school teaching, managing a hardware store and finally, rounding things off by getting close to nature, farming. During this time while getting on a sound economic foundation, he grew in stature, seasoned and mellowed like good wine, and acquired wisdom rich in tradition. He re-entered Emory Medical School in 1926, receiving a degree of Doctor of Medicine cum laude in 1930.

He was an excellent student, but don't think he didn't get around. In the annual one could read of such as the Owl's Club, Susie Dahm's, Society of Wheel, Editor, Debator, Football, Track Team, Chaplain and Poet.

On a fateful day in 1922 he met the charming Jimmie Brown, marrying her in 1923.

After graduation, he interned at Grady Hospital, Atlanta and following this had a two year residency at Steiner Clinic, Atlanta. After this he began the private practice of medicine in 1933 at Brooksville, Florida. Being a solid citizen as he was, he grew with the community, holding many important civic appointments, such as member of the Chamber of Commerce, president of Kiwanis, where he was instrumental in sponsoring and building the Community Hospital, and last but by no means least, he is member of the Methodist Church in Brooksville, serving as chairman of the Board of Stewards for four years.

Now, while busy in civic affairs, don't think for a minute that he was forgetful of organized medicine and the tremendous task that lay before it. He pitched in when duty called, serving on many committees as appointed by different presidents. He was president of the Florida Obstetric and Gynecologic Society in 1957-58, chairman of Council in 1957-58, member of the Citizens Medical Committee on Health appointed by Governor Collins, first vice president of the Florida Medical Association 1958-59, and at present is a member of the Board of Governors, Florida Medical Association, vice-president of the Florida Medical Foundation and a member of the Board of Medical Examiners.

I wish to present to you none other than S. Carnes Harvard for the office of President-Elect of the Florida Medical Association."

Dr. David R. Murphey Jr. of Hillsborough: "Mr. President, and members of the House of Delegates of the Florida Medical Association: I am certain for one time in my career that I appear before you on a noncontroversial subject, and I make this statement advisedly. It is not too difficult to make friends on a weekend basis or on an occasional committee appointment basis and for this reason it is usually customary for a man's own county society to second his nomination. In this instance I believe it would be unprecedented and probably a little bit embarrassing as this candidate comes from a small county with one delegate, and the candidate holds the delegate's badge and the privileges of the floor.

"My county is closely associated with our candidate as a friend and a physician. We know

him to be a good husband, a good father, an outstanding citizen of his community and an excellent physician, and as chairman of the delegation from Hillsborough County I want to second the nomination of Dr. Harvard."

Dr. Robert E. Zellner of Orange: "Mr. President and members of the House of Delegates, about 70 years ago a celebrated English artist, Sir Luke Fildes painted a picture which immediately became famous, because it struck a responsive chord, one which you all know. It is known as 'The Doctor.' It is the picture that was used so widely by the AMA a few years ago publicizing the dedication of a family doctor to his practice. Like many old pictures, this picture has faded somewhat in recent years and sometimes it is not recognized, possibly due to some of the propaganda Dr. Orr told us about. But there are still some places where this picture is a very bright one and one of those places is the little town of Brooksville. Just two years ago when Dr. Harvard celebrated the 25th anniversary of his hanging out his shingle, it was celebrated in a very big way at the surprise party given him by practically all of Hernando County.

"I can think of no finer tribute to a poet, a lover, a scholar, than to say that he is also a very fine doctor, and we in Orange County, being his near neighbors are like the American Tobacco Company which says, 'Among tobacco men, they choose Lucky Strike 2 to 1.' Well, for those who know Carnes Harvard there are no odds at all, we are all behind him. So on behalf of the Orange County Medical Society I would like to second his nomination."

Dr. William C. Roberts of Bay: "Mr. President and Members of the House of Delegates: All these men have been talking about our candidate from areas near his locale. I am far removed from Brooksville. Three years ago he accepted the position as chairman of the Council. Many problems were laid in his lap and he handled them perfectly. He steered the FMA out of the district meetings which is a good thing, I think. If he is head of our Association a year from now he is not going to steer the Florida Medical Association wrong. I plead with you to elect Carnes Harvard president-elect of this Association so we can continue to have a safe, sound, successful and progressive organization."

Several delegates moved that nominations be closed and the secretary cast a unanimous ballot for Dr. Harvard. Motion was duly seconded and carried and Dr. Harvard was elected President-Elect of the Association. The President requested Dr. William C. Roberts and Dr. David R. Murphey Jr. to escort Dr. Harvard to the rostrum.

Dr. Harvard: "Dr. Jack and members of the House of Delegates of the Florida Medical Association: I can tell you right now it is an awful long way from back where I was sitting up to here. I know now why they send two men to escort you up here, to be sure you don't fall by the way. I do think, though, they should have a third man right behind to boost you up on the rostrum. I also feel, after hearing all those nominating speeches, somewhat like Ralph Jack's little boy who was in the chicken coop when he lost his chewing gum—I was a little bit confused to know just whom they were talking about for a little while.

"I have always loved medicine and have always worked at it and in the Florida Medical Association and the work we have done, the little part I have had in it has been a pleasure to me, but I know it is getting a bit ahead of us. I wish to remind you of the words Dr. Orr said, all of which I endorse 100 per cent. I do think it would be wise to remember that 1950 was the first time the doctors really became alert and after that we went back to sleep until the Forand Bill woke us up again.

"I want to congratulate Dr. Jack on his speaker, Mr. Curtis; I think all of you will agree that he was excellent. The part we can play as an organization is great. I feel as individuals we are missing the boat if we don't make the most of our doctor-patient relationship, not particularly to politics, but to keep patients informed and to keep their respect, as always.

"I want to thank you for the honor you have bestowed upon me and I will do my best not to let you down. Thank you."

Dr. Jack: "The Chair will now entertain nominations for the office of Vice-President."

Dr. Henry J. Babers Jr. of Alachua: "Members of the House of Delegates, the Alachua County delegation would like to place in nomination the name of Dr. Clyde O. Anderson of St. Petersburg for vice president of this Association.

"Dr. Anderson's qualifications are known to most of you, but I will quickly list a few of his accomplishments. He attended the University of Florida and Emory Medical School, and has practiced medicine in St. Petersburg since 1933. In

organized medicine, he has been active, he has served as president of the Pinellas County Medical Society and as councilor from district 5. He has served on the Board of Governors of the Florida Medical Association and has served as chief of staff of St. Anthony's Hospital in St. Petersburg. He is on the medical advisory committee of the state welfare board and is vice chairman of the state medical advisory committee of the J. Hillis Miller Health Center. He was secretary-treasurer of the Florida Medical Foundation last year.

"He is one of the members of the FMA's congressional liaison committee.

"In other fields of public service, he has been president of the Alumni Association of the University of Florida, and president of the University's Endowment Corporation. He is a director of the St. Petersburg United Fund. He has received a number of honors because of his various activities. These include the Silver Citizen's Award in 1958 in St. Petersburg, the Alumni Award of the University of Florida in 1955 and the Centennial Award of the University in 1953. He has had the unusual honor of being an honorary member of Blue Key of Florida and of the F Club. He will have a wonderful obituary because of the distinguished things he has done."

Dr. George W. Morse of Escambia: "Dr. Jack and members of the House of Delegates, the Escambia County Medical Society is pleased to second this nomination for Dr. Clyde O. Anderson. I need not add anything to what Dr. Babers has said in introduction of him."

Dr. James N. Patterson, of Hillsborough: "The Hillsborough County Medical Association wishes to second the nomination of our neighbor across the bay, Dr. Clyde O. Anderson. I move that nominations be closed and the secretary cast a unanimous ballot for Dr. Anderson."

Motion was seconded and carried, and Dr. Anderson was elected Vice President.

Dr. Jack: "Gentlemen, we have something new this year. As you all know, under our new Charter and By-Laws, future presidents are not going to have the fun of getting all mixed up presiding over the House of Delegates, since the By-Laws now provide for a Speaker of the House and a Vice Speaker if desired."

Dr. H. Phillip Hampton: "The office of Speaker of the House of Delegates has been created as part of the reorganization of the Florida Medical Association with adoption of the new Charter and By-Laws.

"The new organization will enable the physicians of Florida to more efficiently and effectively shoulder the responsibilities to society that doctors have traditionally fulfilled through individual efforts. In a rapidly expanding society, however, it has become necessary for physicians to cooperatively apply themselves to these responsibilities in order to fulfil our obligations and maintain our freedoms. This new organization is not designed to discard the old but to build on a firm foundation of proven principle based on experiences of the past.

"The new position of Speaker will play an important part in the efficient functioning of our Association. It will greatly relieve the presidency, already overburdened with obligations of administration and public relations and it will provide more coordination for the deliberations and actions of the House.

"The man to fill the position of Speaker should be steeped in the traditional principles of medical practice, experienced in those problems primarily a part of the duties of the president, and able in parliamentary procedures.

"The office seeks the man. We are most fortunate in having a man with just these qualifications tailor-made by destiny to ably fill the post. A man who has been a member of the House of Delegates since 1926, a past president of the Florida Medical Association and the first parliamentarian of the House of Delegates.

"He won his spurs as a parliamentarian in the middle of battle the year he was president—demonstrating a remarkable agility for one with his years of experience. The House had become entangled in a melee of motions, amendments, substitute motions and points of order whereupon our nominee exhibiting a nimble foot, ready wit and thoughtful resourcefulness, brought forth a copy of Robert's Rules from his inner pocket and restored the order to the House of Delegates which prevails today.

"It is my honor, representing the delegates of Hillsborough County, to place in nomination for the office of Speaker of the House of Delegates, Dr. Joseph S. Stewart of Miami."

Dr. Walter E. Murphree of Alachua placed in nomination the name of Dr. Franklin J. Evans of Dade.

Dr. Walter E. Murphree of Alachua: "Mr. President, this is a new office, one that has never been voted on before, and I think it is in order to let the House have a choice in this matter. I wish to place another name in nomination for this position. This man was born in New York City in 1910. He received his LL.B. degree from New York University in 1931. After practicing law for five years in New York City he re-entered New York University and was graduated from the medical school in 1941. Following an internship in Bellevue Hospital, he entered private practice in Dade County, where he remains at the present time.

"At present he has completed ten years on the executive committee and is also the present president of the Dade County Medical Association. From a legal standpoint, he has tried nine criminal cases in court which were of major importance and won eight of them. He was formerly an instructor in medical jurisprudence at the University of Miami and originated and taught courses there to the third and fourth year classes. He is at the present time Assistant Professor of Legal Medicine at the University of Miami School of Medicine and lectures on medical ethics and allied subjects to the third and fourth year students. He is a member of The Florida Bar and the Dade County Bar and many medical organizations. He is a fellow of the American Academy of Forensic Sciences and a member of the American Board of Legal Medicine. From a parliamentary standpoint he has been parliamentarian at many meetings including the annual meetings of the Florida Academy of General Practice. In 1958 he was parliamentarian for Dr. Roberts when he was president of this organization. He was the parliamentarian at the revision of the by-laws of the medical board of Jackson Memorial Hospital in 1954 and 1955. At the coming A.M.A. convention in Miami Beach this June he will co-sponsor an exhibit on parliamentary procedures.

"I wish to place in nomination the name of Dr. Franklin J. Evans of Dade County."

The nomination was seconded by Dr. Walter W. Sackett Jr. of Dade County.

Dr. Harold W. Johnston of Orange: "I would like to make a motion that whoever loses the election for Speaker be unanimously elected as Vice Speaker."

Motion was duly seconded and carried.

Dr. Edward R. Annis of Dade: "I don't think this is a good idea. We are talking about a Speaker and a Vice Speaker from the same area of the state. Wouldn't it be wise to have, as in the case of the presidency and other offices, different sections of the state represented? There are several men in different areas who can bring to the position a lot of information of value, and at the same time develop leadership for the future in other sections of the state. I am automatically against electing two men for any office from any one area."

Dr. David R. Murphey Jr. of Hillsborough: "Mr. President, I move the motion be tabled."

Dr. Murphy's motion was seconded and carried and Dr. Johnston's motion to elect the loser Vice Speaker was tabled.

There being no further nominations, upon motion by Dr. David R. Murphey Jr., nominations were closed and the President asked Drs. Sidney G. Kennedy Jr. and Charles F. McCrory to act as official tellers and ballots were passed out. Upon request by the tellers, three additional tellers were appointed, Drs. G. Dekle Taylor, Henry J. Babers Jr. and Walter J. Glenn Jr.

Dr. Jack: "Gentlemen, while these ballots are being counted there is another piece of business before us to be considered today. The By-Laws state that the election of a Vice Speaker of the House is optional. The Chair would like to have a motion as to whether or not you wish to have a Vice Speaker."

Dr. Walter W. Sackett Jr. of Dade: "I move we have a Vice Speaker for many reasons, absence of the Speaker, sickness, etc. If we are going to have a Speaker we need an assistant too."

Motion was seconded and carried.

Dr. Jack: "The Chair thinks the results of this election should be known before we open nominations for a Vice Speaker. In the meantime the Chair has been able to catch out of the corner of his eye a glimpse of a man whom it is awfully good to see. I just want you to know that Dr. Robert McIver is in the room and we are delighted to have him back. He was Secretary for many, many years and then President in 1952 and he had one of the most enviable attendance records the House has ever had. Glad to see you, Bob.

"To save time, I will now entertain nominations for the office of Secretary-Treasurer."

Dr. Jere W. Annis of Polk: "I am glad to be back here and to nominate your perennial Secretary-Treasurer, Dr. Samuel M. Day."

Dr. Cecil M. Peek of Palm Beach moved that

nominations be closed. Motion was duly seconded and carried and Dr. Day was elected Secretary-Treasurer.

Dr. Jack: "We will now proceed with the election of two delegates and two alternates to the House of Delegates of the American Medical Association. First the Chair will ask for nominations for a two year term beginning January 1961 for the position that is now held by Dr. Reuben B. Chrisman Jr."

Dr. Robert E. Zellner of Orange: "Mr. President and fellow delegates, about ten or twelve years ago you will recall there was a good deal of grass roots criticism about the A. M. A. being run by a bunch of old men. I don't think that criticism was ever justified in the Florida delegation, however, as part of a youth movement eight years ago we elected a man in his thirties who was just building a practice. Now, as a young, mature man he has certainly brought dignity to this delegation. He is on the Council on Medical Service and the Council on Legislative Activities. I recall very well the enthusiasm with which I voted for R. B. Chrisman of Miami eight years ago and I nominate him today with even more enthusiasm to succeed himself as a delegate to the A.M.A."

Upon motion duly seconded and carried, nominations were closed and Dr. Chrisman was unanimously elected as delegate to the American Medical Association for a two year term beginning January 1961.

Dr. Jack: "Our next order of business will be to elect an alternate for Dr. Chrisman, now held by Dr. Frank D. Gray."

Upon motion by Dr. Homer L. Pearson Jr., duly seconded and carried, Dr. Gray was nominated and elected to succeed himself.

Dr. Jack: "The next order of business is for nominations for the delegate's post that is held at present by Dr. Francis T. Holland. This is also for a two year term beginning January 1961."

Dr. Ashbel C. Williams of Duval: "Dr. Francis T. Holland has served as delegate for six years and experience is tremendously important. He has done the job with distinction and I think we are all proud of our Florida delegation. As a member of the Duval County Medical Society, I would like to place his name in nomination."

Upon second by Dr. C. Frank Chunn of Hillsborough, the motion was carried and Dr. Holland was re-elected as delegate to the American Medical Association.

Upon motion by Dr. Cecil M. Peek of Palm Beach, duly seconded by Dr. James L. Borland of Duval, and carried, Dr. Madison R. Pope of Hillsborough was re-elected as alternate to Dr. Holland.

Dr. Jack: "I now have the results of the election for Speaker of the House. Dr. Joseph S. Stewart was elected. Our legal advisors tell me, Joe, that we are now operating under the new By-Laws, do you want to come up and take over for the rest of the time?"

Dr. Stewart: "If the President pleases, I would much rather sit back here and learn for the remainder of this session."

Dr. Jack: "I will entertain motions for the office of Vice Speaker."

Dr. Henry L. Harrell of Marion: "I would like to nominate Dr. Eugene G. Peek Jr., from my county medical society. He has been a member of the Board of Governors and put in a lot of time for the Florida Medical Association and I think he has demonstrated his ability and devotion to this Association."

Dr. Edward R. Annis of Dade: "It is a pleasure to say what I have in mind. Dr. Peek has been a tremendous asset to those of us who have gone up to Washington for the last couple of years. He is the only one I know large enough to look any senator in the eye and stare him down. He has been a great help and his influence is much greater than many of you realize. It is a pleasure to second his nomination.

Upon motion by Dr. H. Phillip Hampton of Hillsborough, duly seconded and carried, nominations were closed and Dr. Peek was elected Vice Speaker of the House of Delegates.

Dr. Jack announced that the results of the election of members of the Membership and Discipline Committee had not yet been completed and would be included in the official proceedings.

Committee on Membership and Discipline

District 1	1961	C. Frank Chunn
	1964	N. Worth Gable
District 2	1962	Ashbel C. Williams
	1963	Raymond H. King
District 3	1963	George H. Garmany
	1962	Sidney G. Kennedy Jr.
District 4	1964	Nelson Zivitz
	1961	Frazier J. Payton
District 5	1961	Duncan T. McEwan
	1964	Herbert E. White
District 6	1962	Frederick K. Herpel
	1963	Miles J. Bielek
District 7	1963	Gordon H. McSwain
	1962	John M. Butcher
District 8	1964	Thomas H. Bates
	1961	William C. Thomas Sr.

Dr. Jack: "This particular moment comes to every President. It is my particular pleasure at this time to ask Dr. Edward Jelks and Dr. Robert B. McIver to escort your President, Leo M. Wachtel, to the rostrum.

"Leo, I have no question about how you will use this gavel this year. I am sure that you will have the same fine cooperation from the entire membership that it has been my pleasure to have this past year."

Dr. Wachtel: "Gentlemen, it now becomes my pleasurable duty to which I have been looking forward to present my predecessor with the past president's pin. Dr. Jack, I don't think anyone could have been more fortunate than I in having you precede me and tutor me in the duties of the office. I congratulate you upon assuming the position of past president. And with it, this certificate which will always be a reminder to you of this hard working year you put in.

"They also serve who only sit and wait—the little woman who stays at home and keeps the home fires burning while the President is on the road. It gives me great pleasure to present to Ruth Jack her husband who has been hanging around the Board Room in Jacksonville for the past year and now may hang at home for awhile. Dr. Maxwell, will you present this portrait of Dr. Jack to Mrs. Jack?

"I want to announce that the post convention Board meeting will take place in the French Room of this hotel and will be very brief. For your information in addition to the men whom you have elected today, which include Carnes Harvard, Clyde Anderson, Joe Stewart and Sam Day, the following will also serve on the Board: Ralph Jack as past president, Jere Annis as past president, Alpheus Kennedy from District A, Phil Hampton from District B, Meredith Mallory from District C, Warren Quillian from District D, Walter Murphree who has been appointed for a one year term at large, John Milton representing the State Board of Health and Francis Holland representing the A. M. A. delegates.

"That is my official family. I would presume on your patience to introduce my unofficial family, who are sitting in the back of the room. My wife, Helen Wachtel and my younger son, John Wachtel.

"I will hurriedly tell the story that is expected of me. The story is that a man went into a bar and had a couple of drinks when he heard a harmonica being played in the back of the room and went over to take a look, and there was a monkey playing the mouth organ with his tail hanging down inside the pickle barrel on which he was sitting. The man went back to the bartender and said, 'Say, did you know there's a monkey sitting back there on your pickle barrel?' And the man said, 'Don't bother me right now, I've got more important things such as federal and state taxes, the Forand Bill, and other things to worry about.' So after a couple of more drinks, when he was fit to talk to the monkey, he went back and said, 'Say, do you know your tail's hanging down in the pickle brine?' And the monkey said, 'No, but if you tell me how it goes, I'll see if I can play it for you.'

"So, as your president for this year, if there is anything that you want played, let me know and I'll see if I can play it for you. The only remarks I want to make at this time are to emphasize the talks you have heard during the session, including Dr. Orr's address today. We might call this our year of the oyster and that oyster is politics. It will take the strength of all of us working together to open that oyster. We are going to have to get our message out through letters to friends and patients and to Congressmen from other states. Thank you."

Dr. Homer L. Pearson Jr. pronounced the benediction.

The Eighty-Sixth Annual Meeting of the Florida Medical Association was adjourned at 5:15 p.m. on Monday, April 11, 1960.

Registration

The total registration for the 86th Annual Meeting at Jacksonville was 1,474. The registrants include 768 members of the Association, 109 visiting physicians, 44 other guests, 290 members and guests of the Woman's Auxiliary, 45 scientific exhibitors and 218 representatives of exhibiting firms. There were 19 other states represented in addition to Florida.

OFFICERS

Ralph W. Jack, M.D., President.....Miami
Leo M. Wachtel, M.D., Pres-Elect.....Jacksonville
Eugene B. Maxwell, M.D., Vice-Pres.....Tampa
Samuel M. Day, M.D., Secretary-Treasurer.....Jacksonville

MEMBERS

APALACHICOLA: Henry I. Langston. ARCADIA: Gordon H. McSwain, Anthony D. Migliore. AVON PARK: Donald C. Hartwell, Claude B. Henderson. BARTOW: Milo H. Holden. BLOUNTSTOWN: Grayson C. Snyder. BRADENTON: Irving E. Hall Jr., Richard V. Meaney, Frederick L. Patry, C. Sumner Quimby, Henry E. Rasmussen-Taxdal, Milton W. Roggenkamp, John A. Shively, William D. Sugg. BROOKSVILLE: George R. Creekmore, S. Carnes Harvard. BUNNELL: John M. Canakaris. CALLAHAN: David D. Bennett Jr. CHATTAHOOCHEE: Clarence H. Denser. CLEARWATER: Lawrence R. Buckley, Helen L. T. Dexter, James V. Freeman, Francis C. Hoare, James B. Leonard, William G. Mason, Samuel T. Register, George H. Schoetker, H. Gerard Siek Jr., Paul L. Summers, Davis H. Vaughan. COCOA: Donald M. Bryan, Laurette M. Bryan, William L. Heimer, Thomas C. Kenaston Sr. COCOA BEACH: Joseph C. Von Thron. CORAL GABLES: Reuben B. Chrisman Jr., Jack Q. Cleveland, Franklin J. Evans, Joseph R. Galluccio, Francis W. Glenn, Thomas S. Gowin, Frederick E. Hasty, Robert P. Keiser, Joseph Lomax, John D. Milton, William T. Mixson, Wesley S. Nock, Irwin Perlmutter, Warren W. Quillian, Ben J. Sheppard, William R. Stinger, James A. Whiteside. CRYSTAL RIVER: Samuel R. Miller Jr. DADE CITY: W. Wardlaw Jones. DANIA: Fred E. Brammer.

DAYTONA BEACH: Fred H. Albee Jr., Michael R. Blais, John J. Cheleden, James W. Clower Jr., C. Robert DeArmas, James H. Demming, Peter A. Drohomer, Gerald L. Ehringer, R. Harrison Freedman, Dolph V. Galloway, David W. Goodard, Richard C. Hartsfield, William L. Jennings, Herbert D. Kerman, Eric H. Lenholt, Edward P. Madden, Achille A. Monaco, Howard W. Reed, Charles L. Rickerd, William W. Schildecker, Thomas E. Scott Jr., Morris B. Seltzer, Perry A. Sperber. DELAND: Theodore F. Hahn Jr., Ben I. Smaller. DUNEDIN: Clifton A. Young, Walter H. Winchester. EUSTIS: Rabun H. Williams, C. McK. Tyre. FERNANDINA BEACH: Benjamin F. Dickens, B. Joe Wilder. FOLEY: Walter J. Baker.

FORT LAUDERDALE: Curtis D. Benton Jr., Miles J. Bielek, Alexander A. Bolton Jr., Russell B. Carson, Burns A. Dobbins Jr., Paul J. Fuzy Jr., Donald H. Gahagen, Walter J. Glenn Jr., Thomas F. Huey Jr., Garland M. Johnson, Floyd A. Osterman, Claus A. Peterson, Leigh F. Robinson, Alvin J. Tight, W. Dotson Wells, Moke W. Williams, Scottie J. Wilson, Kenneth L. Winslow, Keith C. Wold. FORT MYERS: H. Quillian Jones, Joseph W. Lawrence, Thaddeus S. Rodda, John S. Stewart. FORT PIERCE: Russell L. Counts, Hugh B. Goodwin Jr., Martin G. Gould, John N. Sims Sr., Richard F. Sinnott, George Theodorou, Wilbur S. Turner, Laurence D. Van-Tilborg, Lloyd U. Young. FORT WALTON BEACH: Frederick F. Crews. GAINESVILLE: Edwin H. Andrews, Henry J. Babers Jr., F. Emory Bell, Thomas M. Brill, Alva T. Cobb Jr., David A. Cofrin, Eugene H. Cummings, Allen Y. Delaney, Raymond J. Fitzpatrick, William P. Hadley, George T. Harrell, Louis F. Hubener, John E. Maines Jr., George H. Miller Jr., Walter E. Murphree, Charles Pinkoson, George H. Putnam, William C. Thomas Sr., I. Irving Weintraub, Edward R. Woodward. GRACEVLLE: Redden L. Miller. GREEN COVE SPRINGS: Thomas L. Glennan, John M. Malone, Thomas C. Williams Jr. HIALEAH: Duke B. Baird, Leon S. Eisenman, Howard M. Simon Jr. HOLLYWOOD: Alexander H. Bluestone, Andre S. Capi, Anthony C. Galluccio, Russell R. Hippensteel, Robert J. Patterson, Randall W. Snow. HOMESTEAD: Robert A. Douglas.

JACKSONVILLE: Thomas E. Abernathy, Thomas S. Adams, Samuel J. Alford Jr., Risden T. Allen, George A. Anderson, Horace M. Anderson, Sam C. Atkinson, Archie J. Baker, Theodore L. Batchelder, William C. Bayless, S. James Beale, Sullivan G. Bedell, Ferdinand V. Berley, C. Ashley Bird, John B. Black, David O. Booher, James W. Bond, Richard J. Boothby, James L. Borland, Frederick H. Bowen, Jack H. Bowen, Charles W. Boyd, Lee E. Bransford Jr., William H. Brooks, J. Brooks Brown, Robert J. Brown, John R. Browning, Charles H. Burke, John W. Caffey Jr., Lindsey D. Campbell, Cornelia M. Carithers, Hugh A. Carithers, Doris N. Carson, Claude L. Carter, Howard C. Chandler, Joseph L. Chilli, George S. Chriss, William P. Clarke, Cecil C. Collins Sr., Clyde M. Collins, Harry L. Collins Jr., Adolph B. Cone, James J. Conners, Charles D. Cooksey, Silas M. Copeland, Herbert L. Corse, John S. Cowdery, James A. Cranford Jr., J. K. David Jr., James M. Davis, Russell H. Dean, Simon D. Doff, Howard C. Duckett Jr., Ensor R. Dunsford Jr., Lucien Y. Dyrenforth, Ray O. Edwards Jr., Thomas S. Edwards, Merton L. Ekwall, Joseph W. Eversole, Joseph A. J. Farrington, Albert T. Fechtel, Emmet F. Ferguson Jr., Joel Fleet, Joseph D. Foley, Frank L. Fort, Donald B. Frazier, Lois E. Friedl, Irvine K. Furman, Jack Galin, Leonard Garten, Willard R. Gatling, Lawrence E. Geeslin, John M. Gorman, Albert S. Goss Jr., Vernon T. Grizzard Jr., Edgar W. Gurganious Jr., Stephen P. Gyland Jr., Donald R. Hagel, Sidney Halpern, W. Roy Hancock, Albert V. Hardy, O. E. Harrell, William G. Harris, John W. Hayes, Charles F. Henley, Cecil M. Hogan, Alda G. Holliday, Phillip W. Horn, H. Foxworth Horne, C. Harold Houston, Victor A. Hughes, Floyd K. Hurt, William M. Hutchinson, William Ingram Jr., Gordon H. Ira, Thomas M. Irwin, Ivan Isaacs, Walter G. Jarrell, Edward Jelks, Charles O. Joest, Benjamin A. Johnson Jr., Marvin H. Johnston, A. Denton Jones, Millard F. Jones, Apostolos A. Kartsonis, F. Gordon King, Raymond H. King, W. Jerome Knauer Sr., William J. Knauer Jr., J. Ellis Lanier, Daniel L. Lauray (Col.), Elmer E. Leitner, Camillus S. L'Engle Jr., Louie Limbaugh, Thomas H. Lipscomb, Samuel S. Lombardo, Frank G. Long, John F. Lovejoy, Joseph J. Lowenthal, Edward W. Ludwig, James G. Lyerly Sr., James R. McCain, John B. McCall Jr., Bernard J. McCloskey, Charles F. McCrory, William H. McCullagh, Reuben L. McDaniel, Richard W. McDowell, Robert B. McIver, Charles F. McKay, Charles B. Mabry, William S. Manning, A. Mackenzie Manson, Lillian C. Mark, Charles A. Mead Jr., Robert M. Mein, Anson J. Mellion, Carl C. Mendoza, Webster Merritt, John H. Mitchell, Wallace H. Mitchell, Faris S. Monsour Jr., Bernard L. N. Morgan, Kenneth A. Morris, A. Sherrod Morrow, Seymour Morse, Thad Moseley, Herman Moss, Sanford

A. Mullen, Nelson A. Murray, John B. Neal, Richard A. Nelson, Melvin Newman, Frederick Oetjen, Thomas M. Palmer, Lorenzo L. Parks, Benjamin J. Philips Jr., Curtis M. Phillips Jr., Floyd L. Pichler, Rothwell C. Polk, Leo B. Provinsky, George I. Raybin, Paul V. Reinartz, Harry W. Reinstine Jr., Richard V. Reiswig, Ferdinand Richards, Shaler Richardson, Wade S. Rizk, Fleming D. Roach, C. Burling Roesch, Albert D. Rood, Samuel W. Root, John B. Ross, Louis M. Sales, F. H. Schnauss, Irwin C. Schneider, E. Thomas Sellers, Clarence M. Sharp, Robert A. Shashy, W. McL. Shaw, Eugene D. Simmons, Richard G. Skinner Jr., Charles R. Smathers, Edward R. Smith, Lauren M. Sompayrac, Wilson T. Sowder, William J. Spann, John T. Stage, John A. Stephens, Sidney Stillman, Sidney Storch, James B. Strachan Jr., William Stromberg, George M. Stubbs, Edward J. Sullivan Jr., Wilbur C. Sumner, Max Suter, G. Dekle Taylor, J. Champneys Taylor, Leo G. Temples, John H. Terry, Robert Y. H. Thomas, J. Q. U. Thompson, William A. Van Nortwick, Harold D. Van Schaick, Ernest W. Veal, James W. Walker, Newton C. Ware, Edward C. Watt, Nathan Weil Jr., Dwight J. Wharton, William L. Whitehurst, Robert N. Wilcox, Louis A. Wilensky, Albert H. Wilkinson Sr., Albert H. Wilkinson Jr., Ashbel C. Williams, Jean B. Williams Jr., Samuel B. Witten, Jonathan H. Wood, Bertram F. Woolsey, Richard W. Worsham, Robert S. Wynn.

JACKSONVILLE BEACH: Russell H. D. Gillespie. JENSEN BEACH: Richard Q. Penick. KEY WEST: Ralph Herz, Herman K. Moore. LACOOCHEE: William H. Walters Jr. LAKE ALFRED: Edgar B. Hodge. LAKE CITY: Frank E. Adel, Laurie J. Arnold Jr., Thomas H. Bates, Harry S. Howell, Harry A. Nevel, Robert M. Sasso. LAKELAND: Clarence L. Anderson, Jere W. Annis, Samuel J. Clark, John E. Daughtrey, Fred I. Dorman Jr., Fred S. Gachet, Harry E. Halden III, Marion W. Hester, Woods A. Howard, William M. Kummer, Charles Larsen Jr., Coy L. Lay, William P. Logan, Grady E. Longino, James T. Shelden. LAKE WALES: Willard E. Manry Jr. LAKE WORTH: A. Scott Turk, Arthur T. Rask. LEESBURG: Arthur P. Buchanan. LIVE OAK: Irby H. Black, Shirley L. Hadden, Hugo F. Sotolongo. MACCLENNY: John T. Benbow. MADISON: Thomas G. Bouland Jr. MARIANNA: James T. Cook Jr., Courtland D. Whitaker. MELBOURNE: Isaac M. Hay, Theodore J. Kaminski, Arthur C. Tedford, Ludo von Meysenbug. MELROSE: Thomas O. Otto.

MIAMI: Lawrence Adler, James L. Anderson, Edward R. Annis, Thomas J. Baker, George S. Baldry, Hubert A. Barge, Harry E. Beller, Andrew G. Brown, Francis J. Campbell, Gerard F. Carter, Turner E. Cato, James R. Chandler Jr., J. Gerard Converse, Vincent P. Corso, Edward W. Cullipher, DeWitt C. Daughtry, George P. Daurelle, Harold E. Davis, Robert F. Dickey, L. Washington Dowlen, Bruce M. Esplin, John J. Farrell, Frederick E. Farrer, Willard L. Fitzgerald, Richard M. Fleming, M. Eugene Flipse, Hollis F. Garrard, W. Tracy Haverfield, Francisco A. Hernandez, Claude D. Holmes Jr., R. Spencer Howell, James J. Hutson, Paul S. Jarrett, Albert C. Jaslow, Walter C. Jones, Ulfar Jonsson, Harold S. Kaufman, Christian Keedy, Theodore C. Keller, Raymond R. Killinger Jr., Matthew A. Larkin, Warren Lindau, Robert S. Litwak, Donald F. Marion, James H. Mendel Jr., Claude G. Mentzer, Wallace E. Miller, Leon H. Mims Jr., Elwin G. Neal, Frazier J. Payton, Homer L. Pearson Jr., Kenneth Phillips, James H. Putman, Gerard Raap, Hunter B. Rogers, Walter W. Sackett Jr., Ralph S. Sappenfield, George F. Schmitt Jr., Manuel A. Schofman, Donald W. Smith, J. Graham Smith Jr., Clifford C. Snyder, Franz H. Stewart, Joseph S. Stewart, Richard F. Stover, Collins W. Swords Jr., Charles F. Tate Jr., Herbert W. Virgin Jr., Robert C. Welsh, Kenneth S. Whitmer.

MIAMI BEACH: Nelson Zivitz. MIAMI SHORES: Harrison A. Walker. MICANOPY: Carleton E. Van Arnam. MILTON: Eric F. Geiger. MOUNT DORA: Frederick C. Andrews, Fred A. Vincenti. NEWBERRY: George W. Karelas. NEW SMYRNA BEACH: Thomas D. Cook, James J. Cunningham. NORTH MIAMI BEACH: Milton S. Monyek. OCALA: William H. Anderson Jr., Harry M. Edwards, Henry L. Harrell, John P. Moore, Eugene G. Peek Sr., Eugene G. Peek Jr., William H. Turnley, Edwin H. Updike II.

ORLANDO: James D. Bozeman, Louis P. Brady, Cecil G. Butt, Charles H. Carter, Chas. J. Collins, Norman F. Coulter, Francis M. Coy, Elwyn Evans, Harry H. Ferran, L. Paul Foster, Truett H. Frazier, Frank D. Gray, George W. Griffin, Thomas F. Hegert, David Y. Hicks, Theodore F. Hoff, J. Cornall Howarth, Joseph L. Hundley, Eldridge W. Johnson, Harold W. Johnston, Solomon D. Klotz, Newton C. McCollough, Bright McConnell Jr., Duncan T. McEwan, Carl S. McLemore, Charlotte C. Maguire, Meredith Mallory, Fred Mathers, Joseph G. Matthews, Alexander P. Maybarduk, Edward F. Meares, Frederick E. Medlock Jr., Royston Miller, James D. Moody, Pleasant L. Moon, Louis C. Murray, Franklin G. Norris, Joseph E. O'Malley, Louis M. Orr, W. Grady Page, Don C. Robertson, Rodman Shippen, Charles R. Sias, Freeman D. Stanford, John E. Startzman, Joseph L. Stecher, Ernest J. Stevens, W. Dean Steward, Sam N. Sulman, Miles W. Thomley, Robert L. Tolle, John H. Webb Jr., Joseph C. Weisman, Breckinridge W. Wing, Peter B. Wright, Robert W. Young, Robert E. Zellner, Albert M. Ziffer.

PAHOKEE: Ernest C. Johnson Jr. PALATKA: Grover C. Collins, Lawrence G. Hebel, Claude M. Knight, Fairfax E. Montague. PALM BEACH: S. Richard Ombres. PANAMA CITY: William C. Roberts. PENSACOLA: Egbert V. Anderson, Bernard M. Barrett, Elsie R. Broussard, Herbert L. Bryans, Joseph W. Douglas, John R. Emlet, Luther C. Fisher Jr., Chas. J. Heinberg, Frank B. Hodnette, Samuel G. Holmes, Alpheus T. Kennedy, Sidney G. Kennedy Jr., Fariss D. Kimbell Jr., Mozart A. Lischkoff, George W. Morse, Wendell J. Newcomb, John M. Packard, Walter C. Payne Sr., Gretchen V. Squires, Frank E. Tugwell, John H. Whitcomb, Earl G. Wolf.

PORT ST. JOE: John W. Hendrix. RIDGE MANOR: Elizabeth K. Lovejoy. RIVIERA BEACH: Frank M. Hewson Jr. ROCKLEDGE: James R. Doty, Myron L. Habegger. ST. AUGUSTINE: Reddin Britt, William J. Gibson, Charles C. Grace, George C. Hopkins, Vernon A. Lockwood, Joseph A. Shelley, A. Clark Walkup, Herbert E. White. ST. CLOUD: William D. Beamer. ST. PETERBURG: Clyde O. Anderson, Arthur Appleyard Jr., Bernard T. Bell, Elmer B. Campbell Jr., Elmer B. Campbell Sr., John H. Cordes Jr., Charles K. Donegan, Ira C. Evans, Chas. L. Farrington, John P. Ferrell, Earl R. Fox, N. Worth Gable, John M. Hamilton, George F. Hieber, Frederick C. Knight, Alfred D. Koenig, Francis H. Langley, Albert B. McCreary, Norval M. Marr Sr., Daniel F. H. Murphey, Nell T. Pattengale, Jack H. Purcell, Charles L. Rast Jr., John P. Rowell, Walter L. Schafer.

SANFORD: Daniel H. Mathers, Vann Parker, William V. Roberts. SARASOTA: John M. Butcher, Thomas G. Dickinson, Michael A. DiCosola, William S. Hatt, Henry G. Morton, Hugh G. Reaves, Karl R. Rolls, William A. Shannon, Melvin M. Simmons, Robert G. Steele, Hershel R. Stratton, Benjamin H. Sullivan, Samuel R. Warson, Millard B. White, Thomas R. Young Jr. SEBRING: Leldon W. Martin. SOUTH MIAMI: Harold O. Hallstrand, G. Thomas Samartino. STARKE: Aubrey Y. Covington. STUART: John M. Gunsolus.

TALLAHASSEE: Edson J. Andrews, Thomas J. Bixler, Paul J. Coughlin, T. Bert Fletcher Jr., Edward G. Haskell Jr., Francis T. Holland, William J. Hutchison, Odis G. Kendrick Jr., Clarence W. Ketchum, Nelson H. Kraeft, DeHart Krans, Robert H. Mickler, George S. Palmer, Henry L. Smith Jr., Stuart C. Smith, Robert N. Webster, Earl E. Wilkison.

TAMPA: Samuel H. Adams, Ralph C. Aye, William C. Blake, Ernest R. Bourkard, Harold O. Brown, Harold Carron, Frank V. Chappell, C. Frank Chunn, Herschel G. Cole, Richard G. Connar, Lee J. Cordrey, James T. Cowart, Oliver F. Deen Jr., Thomas W. Dorr, William

G. Eckert, Irving M. Essrig, J. Brown Farrior, Richard T. Farrior, Sherman B. Forbes, Chas. McC. Gray, H. Phillip Hampton, John S. Helms Jr., Samuel G. Hibbs, Richard S. Hodes, Herbert B. Lott, Blackburn W. Lowry, Paul J. McCloskey, Richard A. Martorell, Frank A. Massari, William A. Moore III, John DeL. Morris, David R. Murphey Jr., John S. Neill, Thomas F. Nelson, Hugh E. Parsons, James N. Patterson, William M. Rowlett, Mauricio Rubio, Zack Russ Jr., Hawley H. Seiler, Mason C. Smith, Rodney D. Steinmetz, Harold Sutker, Joseph W. Taylor Sr., Joseph W. Taylor Jr., Wesley W. Wilson, Sorrell L. Wolfson, Ulysses A. Young.

TARPON SPRINGS: Lorant Forizs, Peter J. Spoto, Walter H. Wellborn Jr. TAVARES: J. Basil Hall. TITUSVILLE: Jim Morris. QUINCY: Taylor W. Griffin, Hilliard R. Reddick. VERO BEACH: Charles C. Flood, Donald D. Gold, Erasmus B. Hardee, James C. Robertson, Enoch J. Vann Jr. WEST PALM BEACH: Willard F. Ande, Harry E. Bierley, William E. Bippus, Edwin W. Brown, Clarence L. Brumback, James F. Cooney, Joseph J. Daversa, C. Jennings Derrick, William H. Everts, V. Marklin Johnson, Philip O. Lichtblau, W. Ambrose McGee, David W. Martin, Lloyd J. Netto, Walter R. Newbern, Theodore Norley, Ralph M. Overstreet Jr., Cecil M. Peek, William H. Proctor, Raymond S. Roy, James R. Sory, Younger A. Staton, Laurie R. Teasdale. WINTER GARDEN: Albert H. Gleason. WINTER HAVEN: Newell J. Griffith, Chester L. Nayfield.

VISITING DOCTORS

ATLANTIC BEACH: Robert J. Jarrell. BAY PINES: M. R. Himalstein. CLEARWATER: Morris W. Dexter. COCOA: Thomas C. Kenaston Jr. CORAL GABLES: Jack Reiss. DADE CITY: Charles E. Gill. EAGLE LAKE: Ruth K. Nayfield. FORT LAUDERDALE: Diran M. Seropian. GAINESVILLE: L. R. Dragstedt, Wm. F. Enneking, Allen Jelks, Elliot H. Klorfein, E. H. Schultz Jr., Richard T. Smith. GREEN COVE SPRINGS: K. Arnold Gill, E. C. Swanson. JACKSONVILLE: R. C. Aizcorbe, Nicholus G. Alexiou, R. H. Anderson, Edward Avila, James O. Bond, Curtis W. Cannon, Reginald H. Cooke, Joe C. Ebbinghouse, John L. Enyart, N. Vildan Erkan, Jorge G. Fuentes, J. E. Fulghum, Edward S. Furber, Andrew D. Hagan, Doris E. Lake, John L. Mitchell, Russell H. Oppenheimer, Javier Ordonez, D. S. Park, George F. Risi, George Roilidis, Eddy M. Skelfield, Thomas A. Stanford. MACCLENNY: J. M. Alcabes. MELROSE: Allen Graham. MIAMI: Gordon H. Hatcher, Rogelio G. Marcial, George A. Segal. OKEECHOBEE: William H. Preston. PALATKA: Joseph H. Jackson Jr., J. R. Sayers. PALM BEACH: H. Ward Williams. PORT CHARLOTTE: E. J. McLaughlin. ST. AUGUSTINE: Edward S. Miller. ST. PETERSBURG: Louis H. Clerf. SEBRING: William F. Hill Jr. TAMPA: Clark W. Jennings, Lawrence Kahana, Shirley Kahana, Albert G. Lewis Jr., Dayton L. Moseley Jr., Melvin J. White. TARPON SPRINGS: T. J. Diamandis, Beatrice M. Spoto. WEST PALM BEACH: Charles C. Dugan, Robert P. Johnson. WINTER HAVEN: Howard C. Lucas, Harry P. Raymond Jr.

ALABAMA-ANNISTON: Hugh Gray. CALIFORNIA-SAN FRANCISCO: Howard Martin, DISTRICT OF COLUMBIA-WASHINGTON: John F. Dominick, Floyd L. Wergeland. GEORGIA-ATLANTA: Larry Bregman, E. B. Dunlap. DECATUR: Herbert A. Codington. MARIETTA: H. S. Colquitt. SAVANNAH: Lee Howard. ILLINOIS-CHICAGO: John L. Bell, Paul C. Bucy, H. E. Kalsch, John J. Procknow, Carlo Scuderi. MONMOUTH: James W. Marshall. INDIANA-BEDFORD: A. E. Newland. LOUISIANA-NEW ORLEANS: P. H. Hanley, M. E. Lapham. MARYLAND-BALTIMORE: Amos R. Koontz. MICHIGAN-ANN ARBOR: Charles H. Willingham. GRAND RAPIDS: George J. Falbisaner. MINNESOTA-ST. PAUL: Thos. J. Edwards, Richard M. Leick. NEW HAMPSHIRE-MANCHESTER: Rebecca Cohen. NEW YORK-ALBANY: Crawford J. Campbell. JAMESTOWN: H. M. Childress. NEW YORK: Elias Gordon. NIAGARA FALLS: William G. Weare. PEARL RIVER: A. Thomson. YOUNGSTOWN: Gerard Cacio. NORTH CAROLINA-DURHAM: John B. Reckless. OHIO-COLUMBUS: Ruth C. Haynes, Walter M. Haynes. DAYTON: Adrian R. Jensen. PENNSYLVANIA-PHILADELPHIA: E. L. Foltz, Ralph Myerson, W. A. Sodeman, M. J. Sokoloff. SOUTH DAKOTA-BROOKINGS: Dean C. Austin. TENNESSEE-CHATTANOOGA: Robert A. Waters. GREENVILLE: Carl F. Romans. VIRGINIA-CHARLOTTESVILLE: A. J. Paquin. LYNCHBURG: J. E. Haynsworth. WEST VIRGINIA-HUNTINGTON: I. E. Taylor.

Scientific Assemblies

The first Scientific Assembly convened at 9:15 a.m. Saturday, April 9, in the Windsor North Room of the Hotel Robert Meyer. Presiding was Dr. Thad Moseley of Jacksonville. The following papers were read:

"Fungous Diseases of the Lungs," John J. Procknow, Chicago, Assistant Professor of Medicine, School of Medicine, University of Chicago.

"Treatment of Respiratory Infections in Children," Richard T. Smith, Gainesville, Professor and Chairman, Department of Pediatrics, College of Medicine, University of Florida.

"The Role of Antibiotics in the Management of Infectious Diseases," E. L. Foltz, Philadelphia, Staff Member of the Pepper Laboratory of Clinical Medicine, University of Pennsylvania School of Medicine.

"Griseofulvin in the Treatment of Fungous Infections," J. Graham Smith Jr., Miami, Assistant Professor of Dermatology, University of Miami School of Medicine.

At 11:00 a.m. Drs. Procknow, Smith, Foltz and Smith were members of the panel on "Recent Developments in the Treatment of Infections." Presiding was Dr. John M. Packard of Pensacola; moderator was Dr. George T. Harrell of Gainesville.

The Second Scientific Assembly convened at 4:45 p.m. Saturday, April 9, in the Windsor North Room of the Hotel Robert Meyer. Presiding was

Dr. George T. Harrell. The following papers were read and discussed:

"Swimming Pool Granuloma," Joseph A. J. Farrington; Nelson A. Murray and Miss Mildred Jeffries, Jacksonville. Presented by Dr. Farrington.

"Parathion Poisoning and Treatment," Warren Lindau and Roger G. Marcial, Coral Gables. Presented by Dr. Marcial.

"Late Results in Vascular Surgery," James D. Moody, Orlando.

"A Review of 215 Cases of Invasive Carcinoma of the Cervix," Curtis W. Cannon, Howard C. Duckett Jr. and Jean B. Williams Jr., Jacksonville. Presented by Dr. Cannon.

"Teamwork in Massive Bleeding Peptic Ulcer," Emmet F. Ferguson Jr. and Harry W. Reinstine Jr., Jacksonville. Presented by Dr. Ferguson.

"Thoracic and Abdominal Tumors of Infancy and Childhood," Albert H. Wilkinson Jr., Jacksonville.

The Third Scientific Assembly convened at 9:15 a.m. Monday, April 11, in the Windsor North Room of the Hotel Robert Meyer. Presiding was Dr. Franz H. Stewart of Miami. The following papers were read:

"Management of Acute Trauma of the Hand," John L. Bell, Chicago, Assistant Professor of Surgery, Northwestern University Medical School.

"The Treatment of Craniocerebral Injuries," Paul C. Bucy, Chicago, Professor of Surgery, Northwestern University Medical School.

"Problems Peculiar to the Management of Acute Traumata in the Bones of Children," Crawford J. Campbell, Albany, N. Y., Associate Professor at Albany Medical College.

"Blow-Out Fracture of the Floor of the Orbit," John M. Converse, New York, Lawrence D. Bell Professor of Plastic Surgery, New York University College of Medicine.

At 11:00 a.m. Drs. Bell, Bucy, Campbell and Converse were members of the panel on "Management of Acute Trauma." Presiding was Dr Charles K. Donegan of St. Petersburg; moderator was Dr. John J. Farrell, of Miami.

ANNUAL JOINT REPORT

Secretary-Treasurer, Samuel M. Day, M.D.
Executive Director, W. Harold Parham

This report covers the administrative year 1959-60 and is submitted as a brief summarization of the many and varied activities of the Secretary-Treasurer and Executive Office during this period. The Association's over-all activities have been covered in the Board of Governors' and committee reports presented to the House of Delegates where policies are determined.

SECRETARY-TREASURER

The constitutional Secretary has carried out the many and varied duties required by the By-Laws of the Association and the functions requested by the Board of Governors, which include the initiation of official correspondence, notification to members of meetings, and maintenance of official records and papers belonging to the Association. The Secretary also attended as many national, state and Association committee meetings as possible during the year.

Membership of the Association has exceeded all previous records with a total of over 3,700 members. Less than 100 of this number are retired physicians, and an additional 588 physicians were licensed in Florida this year. There are now 7,948 licensed Florida physicians, and of this number approximately 5,150 reside in the state.

The report of the Treasurer, including the financial statements, covers the period January 1 through December 31, 1959. As the Association changed in 1958 from a fiscal year to a calendar year, this report is the first annual financial report based on the calendar year. The books have been audited by Lucas, Catherwood and Associates, Certified Public Accountants, and their Certificate of Audit is incorporated in the statements which appear at the end of this report.

The Board of Governors approved the proposed budget as prepared by the Executive Director in consultation with the Secretary-Treasurer for the 1960 calendar year as follows:

General Expenditures	$ 88,650
Executive Director's Department	18,980
Administration Department	35,840
Public Relations Department	15,090
Publications Department	21,420
Legislative Department	16,010
Building and Grounds	13,310
Reserve (5%)	10,500
	$219,800

This was based upon an anticipated income of $226,000 for the 1960 calendar year as follows:

Dues and Entrance Fees	$146,000
Advertising, Journal & Directory Sales	59,500
Technical Exhibit Space	16,000
Interest and Miscellaneous Income	4,500
	$226,000

The anticipated income is less than that anticipated last year primarily because of approximately $6,000 loss of income from sale of technical exhibit space due to the limited exhibit space for the annual meeting in Jacksonville.

EXECUTIVE DIRECTOR

The Executive Director has carried out the duties and responsibilities as directed by the Board of Governors, which include the general responsibility to carry out the directives of and service to the House of Delegates, Board of Governors, Executive Committee, Officers, and AMA Delegates and the development, organization, coordination and implementation of the over-all activities of the Association, management of finances, executive office, personnel and headquarters building, supervision of annual convention, administrative liaison with the AMA and county medical societies and the rendering of administrative services to certain councils and committees of the Association.

EXECUTIVE OFFICE

The administrative structure of the Executive Office continued during the past year was divided into the Administrative Department, Mrs. Zoe Pack, Director; Public Relations Department, Mr. Eugene L. Nixon, Director; Legislative Department, Mr. Alvin D. James, Director; and Publications Department, Mr. Thomas R. Jarvis, Director. The various duties, activities and committee assignments were allocated to these departments. Additional personnel of the Executive Office are Miss June Palmer, Mrs. Mae Mason, Mrs. Louise Rader, Miss Frances Pesce, Mrs. Marial Kneuer, Mrs. Jane Day, Mrs. Rita Fitzgerald, Mrs. Susan Fontanez, Mrs. Evelyn Bodziony and Mr. H. L. Maree.

CONSULTANTS

Mr. Harry T. Gray of the firm of Marks, Gray, Yates, Conroy & Gibbs continued to serve as legal counsel for the Association, and Mrs. Edith B. Hill as Editorial Consultant. Lucas, Catherwood and Associates are the Association's Certified Public Accountants.

ACTIVITIES

ADMINISTRATIVE ASSISTANCE for the officers, standing and special committees of the Association, maintenance of proper records and files, assistance to county medical societies in planning and implementing programs, and liaison with other national and state medical and lay organizations composed a major portion of the activities of this past year as in previous years.

FIELD SERVICES comprised one of the major activities of the Executive Director, Public Relations Director and Legislative Director during the year. Contacts were made with component county societies, legislators, news media and other organizations in the interests of liaison and carrying out the programs of the Association.

THE JOURNAL of the Florida Medical Association report covers the 12 issues ending with December 1959. There were 47,600 copies printed, which is an increase of 1,145 over the previous year.

Income from advertising for the second consecutive year has been adequate to cover the cost of printing, engraving, paper and drayage incurred in publishing The Journal.

THE FLORIDA MEDICAL DIRECTORY was compiled and 5,500 copies were printed. Each active member of the Association was furnished a complimentary copy.

BRIEFS were prepared and nine issues sent to all members of the Association during the past year.

ANNUAL MEETING required, as in the past, continued attention to the details, records and correspondence in connection with the selection of the scientific program, speakers, technical and scientific exhibitors and other details.

ACCOUNTING AND PURCHASING procedures for the entire organization are maintained on a monthly as well as an annual basis. The posting and crediting of all dues, and acknowledgments to members, the AMA and the county societies as well as the banking are handled in an efficient manner. Daily balances are also now maintained and statistical data are readily available.

SPECIAL PROJECTS carried out during the year consisted primarily of fair exhibits, science fairs, rural health, and promotion of the Florida Medical Foundation. The fourth annual Association awards for medical apti-

tude at the Florida State Science Fair will be presented in 1960. Administrative assistance was provided to the Florida Committee on Rural Health.

PHYSICIAN PLACEMENT service of the Association was emphasized during the year. Personal interviews, a large volume of correspondence with physicians seeking locations, field contacts and an increased correspondence with communities seeking medical care are the major aspects of this activity.

LEGISLATION received special emphasis again this year through assisting the Committee on Legislation and Public Policy in carrying out the Association's program regarding national and state legislation and liaison with governmental agencies regarding health services.

The Association maintained an office in Tallahassee during the entire 1959 session of the Florida Legislature to coordinate the Association's legislative activities and serve as a clearing house for legislators and members of the Association.

PRESS RELEASES on various phases of the 1959 annual meeting furnished to the state's newspapers and complete press facilities maintained during the meeting resulted in excellent state coverage. Special press releases regarding the Association's activities or actions were prepared and distributed during the year as warranted. It is gratifying to note that a high percentage of Association releases was published with little or no alteration by the press.

The Association's popular weekly health column service, "Health Topics," now enters its eleventh year. The format has been modernized, and an intensive promotion program was conducted which resulted in 59 per cent increase in the mailing list.

RADIO AND TELEVISION stations were provided with transcribed programs and films obtained largely from the AMA. Assistance was also furnished to county medical societies in producing local programs.

MOTION PICTURES provided by the AMA were scheduled and obtained for showing to medical and non-medical groups.

LITERATURE published by the Association and the AMA, such as pamphlets, booklets, and brochures, was distributed in large quantities to medical societies and other groups, individual physicians and the public at large through waiting rooms, fair exhibits and other activities. The Public Relations reference library was maintained, and special packets of materials on various subjects were prepared and furnished to medical societies and individuals upon request.

MEDICARE required a great deal of administrative assistance again this year in processing the correspondence and reports on claims, together with processing of committee minutes and directives.

SPECIALITY GROUPS approved by the Association have been eligible to receive administrative assistance from the Executive Office since January 1, 1960. Four specialty societies have taken advantage of the service and negotiations are in progress with several others.

WORKMEN'S COMPENSATION FEE SCHEDULE, which is being renegotiated, has necessitated administrative assistance throughout the year in conducting surveys, preparing statistical data and preparing testimony.

January 13, 1960

Board of Governors
Florida Medical Association, Inc.
Jacksonville, Florida

Gentlemen:

We have made an examination of the books and records of

FLORIDA MEDICAL ASSOCIATION, INC. — JACKSONVILLE, FLORIDA

as of and for the year ended December 31, 1959, and submit herewith the report thereon, consisting of the three exhibits and two schedules listed in the foregoing Index.

This report was prepared on a cash receipts and disbursement basis, modified by depreciation and inventory adjustments, in a manner similar to that of prior years. Also, this report reflects the Association's present interest in certain assets of the Florida Medical Association Pension Trust For Employees, as of December 31, 1959.

The examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as were deemed necessary under the circumstances.

In our opinion the accompanying Statement of Financial Condition and related Statements of Net Worth and Operations presents fairly the financial position of Florida Medical Association, Inc. at December 31, 1959 and the results of its operations for the year then ended, in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

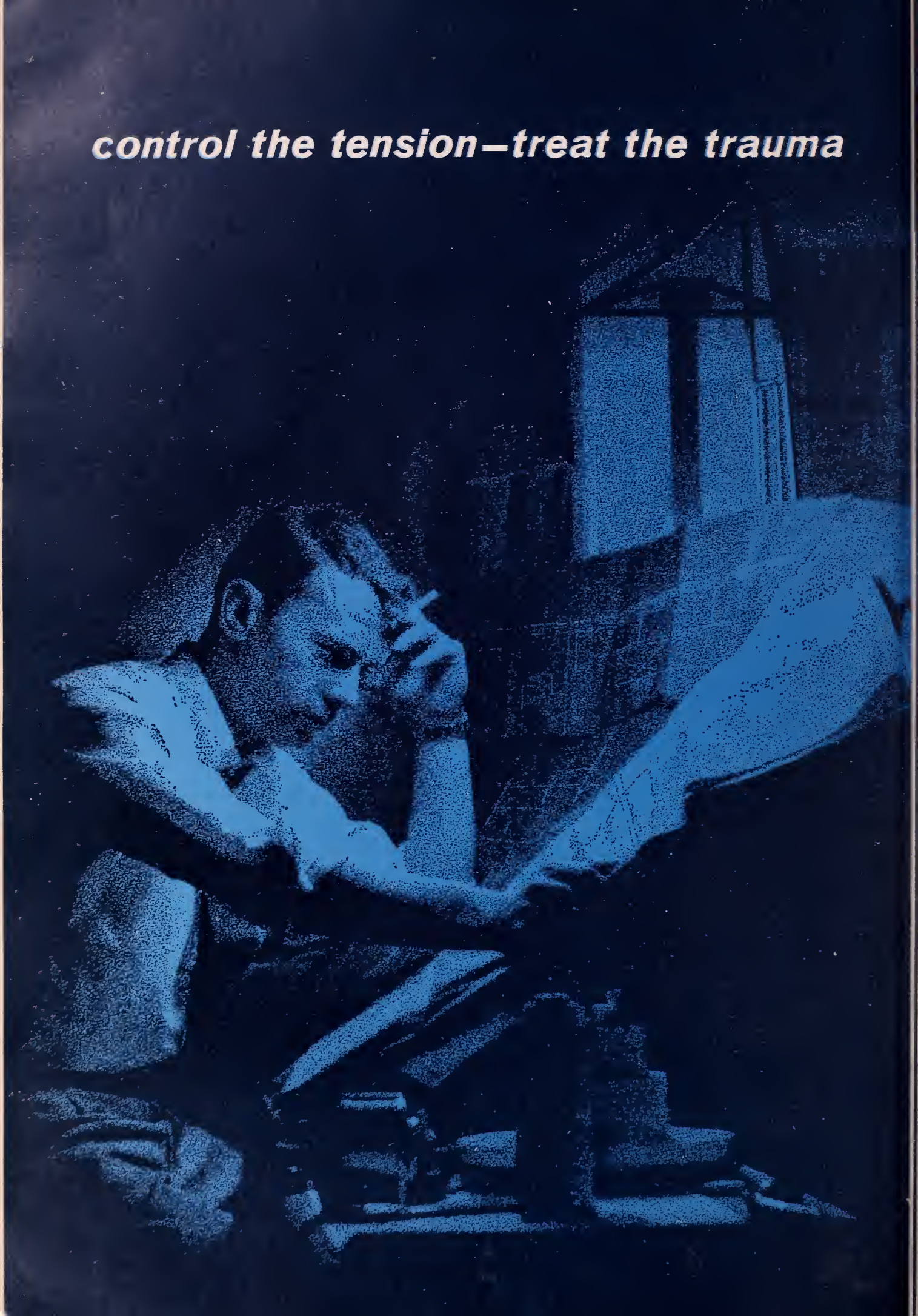
Respectfully submitted,
Lucas, Catherwood & Associates

EXHIBIT "A"
STATEMENT OF FINANCIAL CONDITION
December 31, 1959

FLORIDA MEDICAL ASSOCIATION, INC. — JACKSONVILLE, FLORIDA

ASSETS

CURRENT ASSETS		
Cash On Deposit In:		
Checking Accounts:		
Atlantic National Bank	$ 35,074.80	
Florida National Bank	13,211.69	$ 48,286.49
Savings Accounts:		
American National Bank	10,075.00	
Atlantic National Bank	22,321.91	
Barnett National Bank	5,730.30	
Central National Bank	1,286.15	
Florida National Bank	10,337.42	49,750.78
Petty Cash Fund		105.54


control the tension—treat the trauma

...Pathibamate® 400 200

meprobamate with PATHILON® tridihexethyl chloride Lederle

greater flexibility in the control of tension, hypermotility and excessive secretion in gastrointestinal dysfunctions

PATHIBAMATE combines two highly effective and well-tolerated therapeutic agents:

meprobamate (400 mg. or 200 mg.) widely accepted tranquilizer and...

PATHILON (25 mg.)—anticholinergic noted for its peripheral, atropine-like action, with few side effects.

The clinical advantages of PATHIBAMATE have been confirmed by nearly two years' experience in the treatment of duodenal ulcer; gastric ulcer; intestinal colic; spastic and irritable colon; ileitis; esophageal spasm; anxiety neurosis with gastrointestinal symptoms and gastric hypermotility.

Two dosage strengths—PATHIBAMATE-400 and PATHIBAMATE-200 facilitate individualization of treatment in respect to both the degree of tension and associated G.I. sequelae, as well as the response of different patients to the component drugs.

Supplied: **PATHIBAMATE-400**—Each tablet (yellow, 1/2-scored) contains meprobamate, 400 mg.; PATHILON tridihexethyl chloride, 25 mg.

PATHIBAMATE-200—Each tablet (yellow, coated) contains meprobamate, 200 mg.; PATHILON tridihexethyl chloride, 25 mg.

Administration and Dosage: **PATHIBAMATE-400**—1 tablet three times a day at mealtime and 2 tablets at bedtime.

PATHIBAMATE-200—1 or 2 tablets three times a day at mealtime and 2 tablets at bedtime.

Adjust to patient response.

Contraindications: glaucoma; pyloric obstruction, and obstruction of the urinary bladder neck.

Lederle LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Total Cash			$ 98,142.81	
Deposit—Universal Travel Plan			425.00	
Inventory—Stationery, Postage and Supplies			5,644.51	
TOTAL CURRENT ASSETS				$104,212.32
INVESTMENTS				
U. S. Treasury Bonds—2½% Interest:				
Due 1962-67 (Face Value $1,000.00)—				
At Cost		978.44		
Due 1967-72 (Face Value $15,000.00)—				
At Cost		15,176.93	16,155.37	
Association's Interest In Employees Pension Trust:				
Cash Surrender Values—Life Insurance Policies		6,613.01		
Advance Premiums Paid		17,347.72		
Cash Funds In Trust Account		2,793.57	26,754.30	
TOTAL INVESTMENTS				42,909.67
FIXED ASSETS				
DESCRIPTION	COST	ACCUMULATED DEPRECIATION	BOOK VALUE	
Land	$ 35,833.31	—o—	$ 35,833.31	
Building	122,708.52	$ 12,270.86	110,437.66	
Furniture and Equipment	44,781.04	20,942.48	23,838.56	
Totals	$203,322.87	$ 33,213.34	$170,109.53	
FIXED ASSETS—NET				170,109.53
TOTAL ASSETS				$317,231.52

LIABILITIES AND NET WORTH

NET WORTH				
Net Worth—Exhibit "B"			$317,231.52	
TOTAL NET WORTH				317,231.52
TOTAL LIABILITIES AND NET WORTH				$317,231.52

EXHIBIT "B"
STATEMENT OF NET WORTH
Year Ended December 31, 1959
FLORIDA MEDICAL ASSOCIATION, INC. — JACKSONVILLE, FLORIDA

BALANCE—JANUARY 1, 1959			$246,462.66
ADDITIONS—CURRENT YEAR			
Adjustment To Record Association's Interest In Pension Trust For Employees as of December 31, 1959—Not Previously Recorded:			
Association's Present Interest In Cash Surrender Value of Life Insurance Policies on lives of participating employees	$ 6,613.01		
Advance Premiums Paid	17,347.72		
Cash Funds In Trust Account	2,793.57		
Total Adjustment		$ 26,754.30	
Net Excess of Income Over Expenses—Exhibit "C"		44,014.56	
TOTAL ADDITIONS			70,768.86
BALANCE—DECEMBER 31, 1959—To Exhibit "A"			$317,231.52

EXHIBIT "C"
STATEMENT OF OPERATIONS
Year Ended December 31, 1959
FLORIDA MEDICAL ASSOCIATION, INC. — JACKSONVILLE, FLORIDA

INCOME		
1959 Dues—Schedule C-2	$129,360.00	
1959 Entrance Fees—Schedule C-2	2,770.00	$132,130.00
1960 Dues and Entrance Fees—Schedule C-2		8,750.00

Advertising Income:			
Journal	56,109.90		
Directory	580.00	56,689.90	
Technical Exhibit Income		21,562.50	
Directory Sales		2,774.00	
Contributions—1960 A. M. A. Convention		1,500.00	
Medicare Program		1,399.28	
Interest Income		1,957.00	
Miscellaneous Income		1,079.39	
Journal Subscriptions and Sales		597.08	
Reprints—Non-Members		103.71	
Refund Received From Employee Pension Trust Plan		14,000.00*	
TOTAL INCOME			$242,542.86
EXPENSES—Schedule C-1			
General		37,893.34	
Executive Director		15,454.43	
Business Manager		3,279.34	
Administrative		32,820.90	
Public Relations		12,363.76	
Publications		69,219.53	
Legislative		13,326.75	
Building		14,170.25	
TOTAL EXPENSES			198,528.30
NET EXCESS OF INCOME OVER EXPENSES—To Exhibit "A"			$ 44,014.56

*Non—Recurring—Past accumulations in part.

REPORT OF THE EDITOR OF THE JOURNAL

Shaler Richardson, M.D.

Beginning in July, 1959, certain changes became effective in publication of The Journal. One was appointment of all members of the professional staff of The Journal upon recommendation of the Editor and approval by the Board of Governors. This staff became the Editorial Board with the Editor as Chairman and the duties of members being divided into Committees on Publication, Editorials, Abstracts, Book Reviews and Advertising. Two additional members are designated as Assistant Editors.

The duties of the members of the Editorial Board responsible for publication have not changed. All papers, except those approved by the Editor and Assistant Editors, are reviewed by the Committee on Publication. It is not necessary for all members of the Committee to review the papers, the opinion of one member being sufficient in most instances.

Abstracts are prepared by the Editorial Consultant as in the past and are forwarded to a member of the Committee on Abstracts for approval. In some cases, the chairman of the Committee may request that a certain published paper be sent to a member of the Association not on the Editorial Board who will prepare the abstract.

An editorial on a general subject and an editorial on a medical subject is published in each issue of The Journal. The chairman of the Committee on Editorials has designated that certain issues be the responsibility of the individual member who has the alternative to prepare the editorials or request that they be prepared by some one else. All editorials are sent to the chairman for approval before publication. Certain other materials which may be interpreted as an expression of opinion is also forwarded to the chairman for his evaluation and approval.

All books received by The Journal are sent to the chairman of the Committee on Book Reviews who may request that a review be prepared by the physician whose interests are in the particular subject. All reviews are forwarded to the chairman of the Committee before publication for his approval. In order that the talents of the other members of the Committee may be utilized, the chairman recently requested that only a list of the books be sent to him. From the list, it is his intention to assign those for review by other Committee members.

Advertising is classified as direct, that is, coming directly from the advertiser to The Journal, and national, which comes from the State Medical Journal Advertising Bureau of Chicago.

Advertising from the State Medical Journal Advertising Bureau does not require checking or approval before publication on the part of The Journal. The Bureau has its own personnel and facilities for this task. Most of the advertising in The Journal is placed by the Bureau. Direct advertising may come from various sources within and without Florida, and since little may be known of the advertiser, the firm, and its products, the copy submitted by it requires approval before publication. This is the duty of the Committee on Advertising.

In addition to approving members of the professional staff of The Journal, the Board of Governors of the Association now approves the policy by which The Journal is published. There has been no change in policy which has been approved by the Board of Governors and is recorded in its proceedings.

Volume XLVI, ending with the June issue, had 1,632 pages. A total of 48,625 copies was printed, an increase of 2,170 over the previous volume. Included in the 12 issues were 58 scientific papers and 48 abstracts.

Several changes were made in the appearance of The Journal this year. With the September issue, the new cover design was published. This was the first major change in the cover in eleven years. Each volume will be distinguished by a different color on the cover. The format of several pages was modernized; for instance, the contents page and the first page of the scientific section.

The Journal has had the pleasure of publishing some outstanding scientific material this year and several articles of a nonscientific nature which represented a "first" among medical journals in this country. The Assistant Editors, Dr. Franz H. Stewart and Dr. Webster Merritt, have been instrumental in obtaining scientific material which we were proud to publish.

The Committee on Publication, Drs. James N. Patterson and Chas. J. Collins, have read, and sometimes reread, each paper. When a paper was not suitable for publication, they have often times explained their reasons for rejection for the benefit of the author in case he may desire to rewrite the paper.

Dr. Jere W. Annis, chairman of the Committee on Editorials, and the members of his Committee, Drs. Joseph J. Lowenthal and John M. Packard, have faced deadlines and produced general and medical editorials worthy of comment by other state medical journals.

Dr. Carlos P. Lamar, chairman of the Committee on Book Reviews, has worked hard, not only in getting reviews written, but in getting a routine established so that the task wil be easier for himself and the members of his Committee: Drs. George T. Harrell and W. Dean Steward.

Dr. Kenneth A. Morris, chairman, Drs. Walter C. Jones and Thomas S. Edwards are the Committee on Abstracts and have done an outstanding job.

Lastly, with duties of equal importance with other members of the Editorial Board, is the Committee on Advertising. Dr. Herschel G. Cole, Chairman, Drs. Wilson T. Sowder and Homer F. Marsh.

To all of these, I extend my deepest appreciation for their assistance and advice on the problems we have faced this year. To Tom Jarvis, Managing Editor, Mrs. Louise Rader, Journal Technician, and Mrs. Edith B. Hill, Editorial Consultant, also go my thanks for a good year.

The Journal of the Florida Medical Association

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ABSTRACTS

The Psychiatric Emergency. By Jess V. Cohn, M.D. South. M. J. 52:547-553 (May) 1959.

Stimulated by observation of precipitous interpersonal emergencies and their management both intramurally and extramurally, by growing awareness of the general public regarding matters of mental health and mental illness, and by the learning needs of physicians who are not psychiatrists, the author of this article would remobilize thinking regarding acute psychiatric situations. The mechanism of production of the emergency state in general is discussed, with consideration of homeostasis in the person and in the group, of the meaning of interpersonal relationships, and of the tripartite characteristics of the causation of illness. Consideration is given to the protection of the patient and others concerned, the patient-physician relationship, and the administrative importance of the condition. The occurrence in mental hospital settings is brought into focus, and the occurrence in extramural living is exemplified with brief patient protocols. Education for the nonprofessional public is discussed as is also education of undergraduate and graduate medical students in the methods, both psychiatric and legal, in the recognition and overall disposition of the emergency state. In addition, the advantageous position of the psychiatrist as a consultant to other medical practitioners is considered in terms of the education of the nonpsychiatrist to the dynamics involved, the place of the nonpsychiatrist, and the therapeutic operations in the emergency situation.

Idiopathic Chylothorax: Report of a Case and Review. By Nelson H. Kraeft, M.D. Am. Surgeon 25:401-404 (June) 1959.

It appears not too well known that chylothorax may occur rarely without apparent causative trauma and in the absence of related neoplastic or inflammatory disease. Despite its rarity the possibility should be noted in order to help dispel the specter of obscure neoplastic disease after adequate search has revealed no apparent cause. A case of idiopathic chylothorax is here reported, and it is suggested that the minimal degree of trauma necessary to cause chylothorax and the latent period sometimes existing between the rupture of the thoracic duct and the manifestation of the effusion may explain such idiopathic cases. Prompt evacuation of the pleural fluid by needle or catheter often allows healing of the thoracic duct. When this measure fails, the duct should be exposed and ligated in the chest at the diaphragm. The morbidity and the mortality of such treatment are now minimal.

Frequency of Recovery of Beta Hemolytic Streptococci as Related to Number of Throat Swabs. By Milton S. Saslaw, M.D. Sallie Anne Jenks, and Madelyn Saul, B.S. J. Lab. & Clin. Med. 54:151-154 (July) 1959.

The frequency of recovery of beta hemolytic streptococci from throat cultures has been shown to depend on the number of swabs taken simultaneously. In a prior study, during which duplicate swabs had been collected, approximately one third of the group A organisms isolated would have been missed had a single swab been used. This study was carried out to determine whether or not more streptococcal isolations would result when the number of simultaneous throat swabs is increased. Of 274 throat cultures taken with quadruplicate swabbing, 58 were positive for beta hemolytic streptococci. Considering all groups of beta streptococci isolated, 31 per cent of cultures would have been lost if only duplicate swabs were taken; of group A organisms, 29 per cent would have been lost. The differences observed cannot be attributed to the numbers of colonies recovered. Chance seems to explain the increased frequency of isolation with an increased number of swabs. These data provide warning to the epidemiologist of the danger of relying on the usual throat culture technics to give more than an indication of streptococcal recovery rates.

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 2411, Jacksonville, for abstracting and publication in The Journal. If you have no extra reprints, please lend us your copy of the journal containing the article.

PRESIDENT'S PAGE

Program Document

Following the highly successful Eighty-Sixth Annual Meeting of the Florida Medical Association in April, your officers and Board of Governors met and approved a Program Document for 1960-1961.

This Document, both of necessity because of the continuity of our activities despite changing leadership and through choice because of its merit and the instructions of your House of Delegates, contains many ideas to be pursued which were activated originally in recent past years.

These include:

1. Promoting the programs of liaison with the county medical societies through sponsorship of a Third Annual Conference of Presidents and Secretaries, and the revision of the Handbook for County Medical Societies;
2. Assisting the specialty groups by offering continued administrative assistance and coordinating their activities;
3. Promoting the stated functions of the Florida Medical Foundation and helping to activate an indigent physician fund and a scholarship fund;
4. Promoting the Florida Medical Association Investment Trust and improving it, if indicated;
5. Serving as host, with other Southeastern states, to the 1960 Annual Meeting of the American Medical Association in Miami Beach;
6. Supplementing existent liaison communications with more detailed summaries of Association activities from the President to county society officers, to appropriate committee chairmen, and, when indicated, to officers and certain members of the Woman's Auxiliary; and
7. Following up the activities of previously instituted subcommittees of the Board of Governors.

The biggest organizational effort of the year will be the implementation of the new By-Laws of the Association. Elsewhere in The Journal are listed the numerous new Committees and the newly founded Councils within which they function. The responsibilities, policies, and functions of this new machinery of organization will have to be delineated and set in motion. I call upon each appointee and each member to assist in this monumental task. It is not expected that it can be accomplished without error within this administrative year, but the earnest endeavor of us all will bring us closer to the realization of the intent of the new By-Laws under which we have elected to operate.

Leo M. Wachtel

THE JOURNAL
OF THE
FLORIDA MEDICAL ASSOCIATION

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Medicine and the Conquest of Space*

Captain Ashton Graybiel, MC, USN
U. S. Naval School of Aviation Medicine
U. S. Naval Aviation Medical Center
PENSACOLA

The conquest of space will be man's epic achievement. This conquest pits the desire and genius of man against the fierce hostility of the outer environment and the vastness of the universe. Frail as he is, man will surmount the hazards and, no wiser than he is, will successively solve the problems till he reaches the barrier of distance as a function of time. Throughout the Conquest the laws of nature and the potentialities of man remain as constants, while the accumulation of scientific knowledge and the increase in material wealth will be the variables. We are witness to the beginning of this epic struggle, a beginning which will forever excite the admiration of those who follow and forever define the birth of a new era. For as long as histories of the Conquest are written, at points however distant in time, they must all begin with the brilliant passage of today's achievements.

The relationship of this mighty program to medicine deserves continual analysis. Ideally, this analysis should include every important element which directly or indirectly affects man and mankind. At least this would disclose the opportunities not only for the direct participation but also for encouraging that which is beneficial and discouraging that which is harmful. In considering the interactions between this program and medicine, we must distinguish between the role of the medical profession and its individual members.*

The doctor of medicine, leaving aside direct participants, may be for, against, or indifferent to the exploration of space. Nevertheless, whatever his attitude and whichever his field of special interest, he will feel its impact. This impact has its origin in the requirement for scientific information about man and the behavior of men now available. We must be able to choose with near-scientific accuracy men with the capabilities for carrying out specific tasks and to predict with the same accuracy their future performance. We need

*Opinions or conclusions contained in this paper are those of the author and do not necessarily reflect the views nor the endorsement of the Navy Department.

*This great distinction is difficult to make clear in a word, but the profession has great responsibilities to mankind, and the members of the profession, to man.

to know more concerning their physiological and psychological differences, their physical tolerances and behavioral responses to natural and unnatural stresses, their susceptibility to disease and disorder with all of its diagnostic and prognostic implications. We need to know more concerning the prevention of disease and, more positively, the extension of life span.

Biotechnically, we must supply a synthetic "intermediate environment" which, because of its complexity and small "buffer potential" creates demands which may seem fantastic for a long time to come. Moreover, there is need for medical evaluation at a distance, and the science and art of "telediagnosis" and "teletherapy" are now emerging. To achieve all of these objectives will require an effort scarcely less than that now devoted to missilry. Not to achieve these objectives limits, if it does not endanger, the success of a program which aspires today to send man into orbit, tomorrow to refuel in orbit, and, eventually, to send forth colonizing expeditions. The necessary increase in our knowledge to accomplish these ends cannot fail to advance medical science and medical practice.

The medical profession in its obligation to society has an important role to play. Some opportunities are obvious, such as fostering collaboration between medical and physical scientists. Some opportunities are not directly exposed to view. Thus, the conquest of space may prove to be perfect occupational therapy for an ailing world. At least the conditions are perfect: a psychological ailment and a challenging task. But this must come about as a by-product because mankind is not as yet ready to make great sacrifices for indirect solutions to his problems. To make him ready is an educational endeavor consonant with the highest ideal of the medical profession.

Communication

II. Consultation and Referrals

The importance of adequate communication between physician and patient was discussed in the previous issue of The Journal. The necessity of adequate communication between physicians is of no less importance. In a recent article and accompanying editorial in one of our sister journals,[1,2] it is suggested that one of the reasons for the progressive loss of public esteem and respect for the medical profession is the neglect of intraprofessional etiquette, most notably in the matter of consultations and referrals. The subject is a particularly pertinent one for further comment here in Florida, where the influx of new residents, visitors, and doctors often precludes the establishment of enduring and mutually satisfactory relationship between a family and its doctor. Under the conditions which exist in our state today, it is especially important that there be adequate and informative communication between the doctor in charge of a case and those from whom he seeks advice and counsel.

Perhaps the principal cause for friction between such physicians is lack of clear understanding at the outset of whether the relationship is to be a consultation or a referral. A consultation is generally understood to be a review of the course of a patient's illness with advice as to diagnosis and future management made to the physician who requested the consultation, with the expectation that he will continue the management of the case. Consultation implies cooperation between two physicians. Referral, on the other hand, implies a transfer of the full responsibility of the patient to another physician, either for the course of the immediate illness, or for continued care. If the distinction between consultation and referral were better understood, and were discussed by the two physicians at the beginning of the relationship, there would be many fewer charges of patient-stealing, expressed either openly or as suppressed resentment toward the consultant.

Additional responsibilities fall upon both referring physician and consultant. The referring physician owes the consultant at least a brief outline of the patient's condition and response to treatment, either verbally or in writing. And conversely, the consultant is bound to make a prompt report back to the referring physician. These responsibilities are best fulfilled by a return to the "old-fashioned" etiquette of having the doctor in charge of the case introduce the consultant to the patient and family, and remain in attendance until the consultant has finished his examination, the two physicians have had an opportunity to confer in private, and then together have informed the patient and family of the results of the consultation.

Contrast this ideal situation with what too often happens in our hospitals today. The patient or family is told by the doctor in charge that he will have a "bone man" or a "heart man," et cetera, see the patient, and after ascertaining which physician in the specialty happens to be available, he writes an order on the chart: "Consultation with Dr. Doe." Dr. Doe is notified by the nurse, arrives at the hospital to find a chart blank except for brief nurses' notes, and introduces himself to the patient, often to find that the patient either does not know why he needs a consultation in Dr. Doe's specialty, or that the patient has been under the care of another competent physician in the same specialty. If Dr. Doe completes his examination, but postpones writing a consultation note because of other appointments, there is obviously a complete breakdown in communication and an understandable distaste on the part of the patient, his family, and both physicians concerned.

If the patient's welfare be our chief concern, as it should be, then both the referring physician and the consultant should make conscious efforts to improve communications regarding the patient. Only in this way will the patient receive the optimum in medical care. The medical profession will also benefit, although less directly, in a gradual return to the position of respect and esteem in the eyes of the public, based on our intraprofessional etiquette as well as on the courtesy and consideration extended to the individual patient.

J.M.P.

1. Howe, H. F.: Procedures in Consultation and Referral, New England J. Med. 260:1251-1257 (June) 1959.
2. Editorial: Relations Among Physicians, New England J. Med. 260:1294-1295 (June) 1959.

The 1960 Annual Meeting in Retrospect

For the first time in 14 years Jacksonville was recently privileged to be host to the physicians of the state for their annual convention. The Eighty-Sixth Annual Meeting of the Florida Medical Association was held on April 8 to 11 at the Hotels Robert Meyer and George Washington in the Gateway City, where the Association was organized in 1874 and has through the years maintained its headquarters.

Planned to encompass the weekend, the program opened with the first meeting of the House of Delegates on Friday afternoon and concluded with the second meeting of that body on Monday afternoon. The General Session was held on Saturday afternoon, and the three Scientific Assemblies took place on Saturday morning, Saturday afternoon following the General Session, and Monday morning. Sunday was devoted entirely to specialty societies. This schedule, an innovation this year, was so favorably received that it will probably be adhered to for the 1961 meeting, to be held at the Americana Hotel in Miami Beach on May 26 to 29.

Dr. Leo M. Wachtel of Jacksonville was the incoming President, succeeding Dr. Ralph W. Jack of Miami. Chosen President-Elect to succeed Dr. Wachtel was Dr. S. Carnes Harvard of Brooksville. Dr. Clyde O. Anderson of St. Petersburg was elected Vice President. First to be elected to the newly created office of Speaker of the House was Dr. Joseph S. Stewart of Miami, and for the new post of Vice Speaker the choice was Dr. Eugene G. Peek Jr. of Ocala. Dr. Samuel M. Day of Jacksonville was re-elected Secretary-Treasurer. Elected to succeed themselves as delegates and alternates to the House of Delegates of the American Medical Association for a two year term beginning in January 1961 were Dr. Reuben

Dr. Wachtel

Dr. Day

B. Chrisman Jr. of Miami and his alternate, Dr. Frank D. Gray of Orlando, and Dr. Francis T. Holland of Tallahassee and his alternate, Dr. Madison R. Pope of Plant City.

President Jack in his timely and stimulating Presidential Address, presented before the first meeting of the House of Delegates and published in this issue of The Journal, spurred the members of the Association to meet the challenge of a nation already weakened by apathy and now under attack "by a malignant parasitic disease we call 'socialism'." He reminded them of their dual role as good physicians and also expert teachers—teachers both of history and reality—and pointed out that this country's standards of medical practice and achievement will remain the highest in the world "only so long as Medicine remains free of government and solves its own problems by its own dynamic individual and collective response to the challenges presented to it."

The President's guest was the Honorable Thomas C. Curtis, distinguished Republican Congressman from Missouri and long time friend of Medicine. In his stirring address on "Advancements in Health, Education and Welfare," presented before the General Session, he set forth concisely and convincingly the social and legislative aspects of the problems that beset Medicine today, including the evils of the Forand Bill, and charted a constructive course leading to solution of these problems, of which he is an ardent and forceful champion in the Congress. Every member of the Association will find it well worth while to give this message a thoughtful reading when it is published in the July Journal.

At the second meeting of the House of Delegates and concluding session of the convention, the Association was privileged to hear its most distinguished member and delegate, Dr. Louis M. Orr of Orlando, President of the American Medical Association. His address on "No One Without Adequate Medical Care" appears in this issue of The Journal. It merits careful perusal for it draws the battle lines and sets the record straight in emphatic terms on the vital issue of medical care for the aged and the distorted picture the proponents of Forand type legislation are drawing for the American public.

The attendance at the three Scientific Assemblies was exceptionally good this year. The efforts of the Committee on Scientific work to correlate for the first time the programs of the special interest groups and the Scientific Assemblies was most rewarding and evoked wide interest. The eminent guest speakers of the various specialty societies discussed "Recent Devolpments in Treatment of Infections" at the first Assembly and at the third Assembly discussed "Management of Acute Trauma." The miscellaneous program of the second Assembly was presented entirely by members of the Association.

Among the many important actions of the House of Delegates were the following:

Approval was given to the progress report of the Committee on Representatives to Industrial Council in its efforts to negotiate a satisfactory fee schedule. It was pointed out that the work of this Committee has been hampered by failure of more than half of the county medical societies to return an important questionnaire seeking vital information from which to determine the usual and regular charges made by physicians in industrial cases in the different areas of the state. The ef-

ficiency of its work and its success in attaining its ultimate objectives naturally will be commensurate with the cooperation accorded it by the county medical societies and especially the individual members.

In adopting the report of the Committee on Commercial Health Insurance, the House gave approval to standard simplified claim forms worked out with the Health Insurance Council. All insurance companies operating in the state will be informed of the Association's approval of these forms and urged to adopt such standardized forms. It was noted in the report that last year's resolution dealing with an increase in fees for life insurance physical examinations has resulted in many companies, acting on an individual basis, adopting a $10 fee, which probably will become universal in a short time.

Among approved recommendations of the Committee on Medical Education and Hospitals was one item providing that a law be drawn up and enacted at the next session of the legislature

Dr. Harvard

In addition to Dr. Wachtel, Dr. Harvard and Dr. Day, the other officers of the Association are (left to right) Dr. Clyde O. Anderson of St. Petersburg, Vice President; Dr. Joseph S. Stewart of Miami, Speaker of the House, and Dr. Eugene G. Peek Jr. of Ocala, Vice Speaker.

requiring that "100 per cent of patients be available for teaching purposes at all schools teaching medicine and receiving a subsidy from the State of Florida." The House also concurred in another recommendation which expressed the philosophy that physicians should not surrender the practice of medicine to others including the federal government and that "each state should maintain the control of its institutions; and the staffing of these institutions, and the expenditures necessary for same, regardless of the source from which the wealth comes to maintain them. This should be done regardless of the amount necessary to be appropriated to meet this need."

In reviewing significant changes, the Board of Governors in its report announced that under the new Charter and By-Laws, which became effective during the year, every provision had been implemented when feasible, but the new council and committee system and positions elected by the House of Delegates were being implemented as of April 11, 1960, at the beginning of the Association's new year. In accordance with one provision, the Board selected four nominees from each of the eight Congressional Districts to be voted upon by the House to select two physicians from each District to serve on the Committee on Membership and Discipline. From this number the 16 member committee was elected.

Particularly noteworthy was the Board's announcement of the execution of a Trust Agreement and Declaration of Plan with the Florida National Bank of Jacksonville to implement the FMA Investment Trust as approved by the House of Delegates last year and recommended by the Committee on Medical Economics. The Board appointed the FMA Investment Trust Committee, and the Restricted Retirement Trust was made available to the membership as of April 1, 1960. A brochure describing the Plan with application for participation was mailed to each member of the Association. The Plan marks an important milestone of progress for the Association and has aroused much interest. Members are encouraged to contact the Investment Trust Committee regarding details of the Plan.

Of special interest to every member of the Association is a statement of policy, binding upon all members, which was recommended by the Board and adopted by the House. This declaration, which pertains to indigent care and reaffirms the Principles of Medical Ethics, is:

> *Statement of Policy*—Physicians' services shall be made available without charge to those patients who are recognized and declared to be indigent as so determined through application of criteria as approved by the respective component county medical societies of the Florida Medical Association.

The Medicare Mediation Committee recommended that the Association continue to cooperate in caring for the medical needs of the dependents of members of the Armed Services and extend its contract with the Office For Dependents' Medical Care. The House concurred in this recommendation, thereby authorizing renewal of the contract.

The comprehensive report of the Committee on Legislaion and Public Policy was adopted by the House as amended. This action gave approval to the Revised Medical Practice Act.

A timely resolution regarding H.R. 4700, commonly known as the Forand Bill, was presented by the Board of Governors in a supplemental report and adopted by the House. This resolution commended those members of the House Ways and Means Committee, the Administration and others who forthrightly opposed H.R. 4700 and expressed the Association's admiration, appreciation and commendation to these groups and individuals for their courage, interest and foresight in behalf of all who are concerned with this problem.

The Florida Plan for Care of the Aged and Needy Sick, covered in a second supplemental report of the Board of Governors, was also adopted by the House. This Plan has aroused keen interest in Washington and elsewhere. Its three

Opposite Page

Highlights of the Eighty-Sixth Annual Meeting in Jacksonville: 1. Registration of delegates for House of Delegates sessions; 2. The House in session; 3. Invocation at the General Session by the Rev. Albert J. Kissling, pastor of Riverside Presbyterian Church, Jacksonville; 4. Address of Welcome by Dr. Floyd K. Hurt, president, Duval County Medical Society; 5. The Honorable Thomas B. Curtis, Webster Groves, Mo., member, U. S. House of Representatives, guest of President Jack; 6. Escorting of Dr. S. Carnes Harvard, Brooksville, President-Elect, to the platform by Drs. William C. Roberts and David R. Murphey Jr., Past Presidents; 7. The Past Presidents' breakfast; 8. Greeting Dr. and Mrs. Jack at the President's Reception; 9. Greeting of Dr. Leo M. Wachtel, incoming President, by Dr. Jack; 10. Opening of the Scientific Assemblies by Dr. Thad Moseley, Jacksonville, Chairman, Committee on Scientific Work; 11. Presentation of Certificate of Merit to Dr. Jack by Dr. Wachtel; 12. Presentation of official gavel to Dr. Wachtel by Dr. Jack.

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basic features are a program to provide hospital and medical care for the needy sick of all ages; medical supervision with the practicing medical profession having a responsible position in planning and management; and a state and county matching fund with financial and administrative responsibility remaining on the local government, with voluntary participation by the individual counties. Several years ago, officials of the Florida Medical Association initiated the studies from which this Plan evolved, implemented it through the Governor's Citizens Medical Committee on Health, have since amply demonstrated their ability to assume the responsibility of supervision and have formed the Florida Medical Foundation for that purpose. They regard federal matching funds now available to states for medical service to welfare recipients as too restrictive by regulation to encourage states to develop their individual programs. They believe, however, that good, economical and effective medical care for the aged and needy sick of all ages is primarily a state and community responsibility which could be provided by individual state plans.

Experience with the Florida Plan leads to the conclusion that such state plans could be encouraged by the Congress if three fundamental changes were made in regulations concerning the use of federal matching funds in state medical care programs:

1. Federal matching funds for a state medical care program should not be limited to categories of the needy sick, such as the blind or aged, but should be available to be used in providing medical, hospital and nursing home care and drugs for all those in need of care as locally determined without the means of providing for themselves.
2. Federal matching funds for state medical care programs for the needy sick should be appropriated and administered at the federal and state levels separate from funds used for subsistence programs. The practicing medical profession should have a responsible position in planning and management of those medical programs which can best be done through state agencies under medical direction.
3. The local or county governments should be permitted to voluntarily participate in the matching fund program to provide medical care for the needy sick just as states may voluntarily participate in the federal matching program, thus encouraging community interest and responsibility in providing this care.

With these provisions met, the states would be in a position to develop individual programs which would be more effective and more economical than any single national program. These state plans, together with the voluntary health insurance plans for those who can provide for themselves, would then make good medical care available to everyone.

By favorable action on the report of the Council, the House sanctioned its recommendation that the physicians practicing in Clay County be granted their request for a separate component county medical society to be known as the Clay County Medical Society. This new organization becomes the fortieth component society within the framework of the Association.

Life membership certificates were issued this year to 27 members. These certificates are awarded annually to those members who have held membership in the Association for 35 years as a token of appreciation for their long years of service.

The Board of Governors in its report announced the establishment of a subcommittee to recommend a general practitioner of the year. This committee is empowered to make nominations and also to accept nominations from the county medical societies and from the Florida Academy of General Practice. The physician recommended becomes the nominee from Florida to the American Medical Association for consideration as the national general practitioner of the year.

In compliance with a provision of the new By-Laws, the Board of Governors has created four Medical Districts in the state on the basis of physician population. These Districts have been designated North Medical, West Medical, East Medical and South Medical.

The total registration this year was 1,474. Of this number 877 were physicians, 768 of whom were members of the Association and 109 visiting physicians. Other guests registered numbered 44, and there were 45 scientific exhibitors and 218 representatives of exhibiting firms. Two hundred ninety members of the Woman's Auxiliary and their guests were in attendance. Represented in the registration were 19 states in addition to Florida.

Eighty-Seventh Annual Meeting
Florida Medical Association
May 26-29, 1961
Miami Beach

How to Discuss a Paper

The physicians attending the scientific sessions of the 1960 meeting of the Florida Medical Association heard a group of excellent subject presentations, and showed their appreciation of the essayists by being a part of a large and responsive audience.

One criticism of these sessions seems warranted. This concerns the type of discussion carried on upon occasion following the primary presentation. In several instances, the discusser used his alloted time and the privileges of the floor to present a summary of material compiled from his own experiences, which, while interesting, neither contributed to nor disagreed with the previously presented information and was, in effect, an additional paper.

A discusser is one who discusses. This definition places little limitation upon the subject matter introduced by a discusser; yet this very lack of restriction forces this person to rely upon sound judgment and common sense to control the natural impulse to examine his own experiences, compile his own statistics, and share these with an audience having a common interest.

Dr. Lester R. Dragstedt, in his discussion of a paper presented at that meeting, exemplified all that seems most worth while. He presented a well organized, concise discussion, supporting those ideas within the preceding work with which he agreed, questioning intelligently those portions with which he was not in full agreement, but limiting his own comments to the boundaries imposed by the paper under discussion.

Each of us could profit by this example.

Thad Moseley, M.D., Chairman
Scientific Work Committee

American Medical Association Miami Beach Meeting June 13-17, 1960

This month Florida welcomes to its most popular resort area the American Medical Association for its 109th Annual Meeting. The House of Delegates will convene in Miami Beach on Monday, June 13, at 10 a.m. in the Ballroom of the Americana Hotel, which is headquarters for the meeting. The Scientific Assembly will open with the General Scientific Meetings on Monday at 1:30 p.m. and on Tuesday, June 14, at 9 a.m. in the Ballroom of the Fontainebleau Hotel. Sections of the Scientific Assembly will follow at 2 p.m. on Tuesday, all day Wednesday and Thursday, June 15 and 16, and on Friday morning, June 17. The Miami Beach Exhibition Hall and Auditorium will house the scientific and industrial exhibits. The registration Bureau will be located near the main entrance to the Exhibition Hall.

The illustrious President of the American Medical Association, Dr. Louis M. Orr of Orlando, is the first member of the Florida Medical Association ever to hold Medicine's highest office. It becomes his privilege to conclude on home soil his year of distinguished service as Medicine's leader when he yields the gavel to Dr. E. Vincent Askey of Los Angeles, who will succeed him. Dr. Askey will be inaugurated as President at a special Inaugural Ceremony on Tuesday evening, June 14, in the Grand Ballroom of the Fontainebleau Hotel. The Inaugural Ceremony is open to physicians and their families, exhibitors, and guests, and will be followed by a reception and ball.

The general chairmen of the local committees on arrangements are Dr. Reuben B. Chrisman Jr., who heads the Florida Medical Association's delegation to the House of Delegates of the American Medical Association, and Dr. Homer L. Pearson Jr., who for some years has held the distinction of being chairman of the Judicial Council of the American Medical Association. Associate chairmen on arrangements are Dr. Franklin J. Evans and Dr. Robert P. Keiser.

The President's Reception Committee, of which Dr. Ralph W. Jack is chairman, is composed of 23 past presidents of the Florida Medical Association. Many other members of the Dade County Medical Association and of the Florida Medical Association will be laboring faithfully and well to make this first annual meeting of the American Medical Association ever to be held in Florida a great success and an occasion long to be remembered.

Hail to the Chief

This month, Dr. Louis M. Orr, of Orlando, steps out of the No. 1 spot in world Medicine when he relinquishes the presidency of the American Medical Association to his successor, Dr. E. Vincent Askey of California. The Association offices in Chicago, and organized Medicine throughout the country, will feel a loss when "The Chief" steps down.

Throughout the year, he has conscientiously and ably represented us—in Washington—in the other capitals of the world—in the daily press and to the lay public. He has guided with a firm and unfaltering hand the destiny of American Medicine through these troubled waters of socialism, Forand-type legislation and the growing centralization of government. His decisions have been sharply drawn, his voice in our behalf firm and clear, his ideals uncompromising. He has represented us professionally to the Physicians of the world in a favorable and flattering manner, and he has furnished a symbol of integrity of purpose, tenacity of ideals and devotion to mankind for all to contemplate.

He has accomplished much for us all in this his year of endeavor, and has performed a Titan's job in a Titan's manner. We are proud of him here at home and welcome him back again to the practice and the friends that he loves.

And so—if Florida has had but one President of the American Medical Association—it has had one of the best. Congratulations, Chief, on a magnificent year. Thanks for the job you did for all of us—and welcome home.

J. W. A

Jacksonville's Cardiopulmonary Laboratories

The recent establishment of cardiopulmonary laboratories in Jacksonville is one of the tangible results of Jacksonville Hospitals Educational Program. This organization, incorporated in 1958, represents the combined efforts of six hospitals (Baptist Memorial, Brewster, Duval Medical Center, Hope Haven, St. Luke's and St. Vincent's) to upgrade graduate and postgraduate medical education of the nonuniversity hospital. One of the cardinal principles of the organization is the pooling of facilities where this makes for more efficient functioning and an improvement in such facilities.

A well functioning cardiopulmonary laboratory depends upon certain accurately performed chemical procedures. A laboratory for such determinations has been opened in the Jacksonville Blood Bank. It is equipped to determine oxygen and carbon dioxide in blood and in air as well as pH and pCO_2 of blood. These determinations now available have permitted rapid progress in not only pulmonary function studies, but in more careful evaluation of various cardiac lesions, particularly those amenable to surgery. Funds for technical help in this laboratory are being furnished by the Northeast Florida Heart Association and the Duval County Tuberculosis Association.

Laboratories for performance of pulmonary function tests are located in St. Luke's Hospital and in Duval Medical Center. The study of pulmonary disease by modern methods dictates that such facilities be available. In the study of certain patients in whom chest surgery is contemplated, such studies are mandatory. Medicine has moved from its "pathologic phase" to its "phy-

siologic and biochemical phase," and such studies should be available.

Cardiac catheterization has now reached the stage of development where it becomes more of a diagnostic than a research tool. Equipment for this is costly. A central catheterization laboratory, located at Duval Medical Center, admirably serves the needs of the community. Patients, irrespective of where they are hospitalized, have this procedure performed, when indicated, at Duval Medical Center. Funds for equipping this laboratory were furnished by the Northeast Florida Heart Association.

Open heart surgery, now rapidly leaving its embryonic stage, has been made available to this area. A Kay-cross pump oxygenator has been purchased with funds furnished by the Northeast Florida Heart Association. In order for the surgeon to perfect techniques and to learn the nuances of pump operation, an experimental laboratory, located in the basement of the isolation building at St. Luke's Hospital, has been established. This laboratory, financed by member hospitals of the Jacksonville Hospitals Educational Program, is also being used for other experimental studies.

Thus, this Program, which is a community medical education program, including all its ramifications, has sparked the development of facilities in this area which are costly and which require highly skilled personnel for their operation. The coordination of facilities has made these essential operations possible. Avenues for research have similarly been opened.

1960 State Science Fair Awards

The Florida Medical Association's 1960 State Science Fair Awards for Medical Aptitude were presented on April 9 during the awards ceremony in Melbourne. The Science Fair was held April 7-9 at Melbourne High School.

Because of the conflicting dates with the Association's annual meeting, the awards were presented in President Ralph W. Jack's behalf by Dr. Cyrus E. Warden of Melbourne, president of the Brevard County Medical Society. The awards this year marked the fourth consecutive presentation by the Association. For the second year, the Woman's Auxiliary to the Association awarded four honorable mention prizes.

Dr. Cyrus E. Warden of Melbourne, president of the Brevard County Medical Society, congratulates Donald A. Shreve of Woodrow Wilson School, Tampa, prior to presenting the award to him as winner of first place in the junior division for medical aptitude of the 1960 State Science Fair. Winner of first place for medical aptitude in the senior division was Chris Chermiak of Melbourne High School, Melbourne (center).

First place in the senior division (grades 10-11-12) was won by Chris Chermiak of Melbourne High School, Melbourne. His exhibit was entitled "Subcortical Stimulation as a Reward in Behavior Experiments." First place in the junior division (grades 7-8-9) was taken by Donald A. Shreve of Woodrow Wilson School, Tampa. The title of his exhibit was "The Development of a Chicken Embryo." Each of the winners received a hand-lettered citation and a cash prize.

The honorable mention awards, which were presented by Mrs. Clarence R. Crandall of Eau Gallie in behalf of the Woman's Auxiliary to the Association, were won by: David Muchow of Winter Haven High School, Winter Haven; Marshall Crosby of Gainesville High School, Gainesville; Norman R. Jaffe of Landon High School, Jacksonville, and John Patterson of Robert E. Lee High School, Jacksonville. The titles of the exhibits were respectively: "Cancer in Plants;" "Bone Marrow Transplants;" "The Effect of an Antileukemia Drug on Normal Cells" and "The Effect of Color on the Activity of Rats." The honorable mention winners also received hand-lettered certificates and cash prizes.

Special certificates of recognition were presented to the 70 students whose exhibits were judged for medical aptitude. According to Dr. Clarence R. Crandall of Eau Gallie, chairman of the Association's Committee on Awards arrangments, "These certificates were the only award received by many exhibitors and received much favorable comment and attention by visitors, parents, and other exhibitors."

The Association's judging committee consisted of the following physicians: Dr. Warden, Dr. Jack T. Bechtel of Indialantic, and Dr. Michael J. Foley and Dr. Gordon E. Kibler, both of Melbourne.

BLUE SHIELD

You're in Big Business, Doctor

Even in a country where stories of rags to riches are commonplace, the unprecedented growth of the "Blues" is nothing short of amazing. In less than a quarter of a century after enterprising doctors in California initiated, organized and financed the first Blue Shield Plan, some 73 medical society-sponsored, nonprofit Plans have been established throughout the United States, Puerto Rico and Canada, with a total membership of 44,792,923 at the end of 1959.

As the first few Blue Shield Plans struggled through their early years, continuously in strained financial circumstances, few of those hardy, pioneering physicians who sponsored them would have predicted the extent of the response of the public to this method of prepayment for the expenses of illness. Last year these many millions of subscribers paid into their respective Plans the significant sum of $736,941,863. In turn, these Plans returned to their subscribers, in the form of benefits, $664,301,706, or better than 90 per cent of subscriber income. This is your business, Doctor, and it is rapidly nearing the billion dollar category.

A survey of the situation on the state level is equally impressive. In Florida, in 1959, income from Blue Shield's 810,114 members totaled $9,265,679, of which almost 90 per cent, or better than $8,000,000, was paid to Florida physicians for providing professional services to Blue Shield subscribers. Truly, this is a multimillion dollar business, the policies and practices of which are determined by Florida doctors of medicine. Under their sponsorship, supervision and guidance Blue Shield of Florida has grown from an unsteady fledging in 1946 to number 13 today out of 73 Plans. If the present rate of growth is maintained, it is anticipated that in another year it will have attained that select top group of Plans, each with over one million members.

Spectacular as it is, big as it is, Blue Shield must continue to grow and expand. There is nothing static about the business of providing protection against the costs of illness. One must advance or retrench. It is impossible to stand still. Its position of leadership in the field will be strengthened by the recent addition of Extended Benefits and Master Medical Endorsements to basic coverage. Today, Blue Shield in Florida is stronger than ever. Through the cooperation and dedication of the medical profession it will continue to meet the needs and demands of the public. The very bigness of the "Blues" makes them tempting targets for competitors, social planners, and, regrettably, some subscribers and doctors. Being big, nonprofit, and the leader in the field places Blue Shield in a goldfish bowl, into which every citizen believes he has the right to peer, and to have a say in determining the specimens that are on exhibition.

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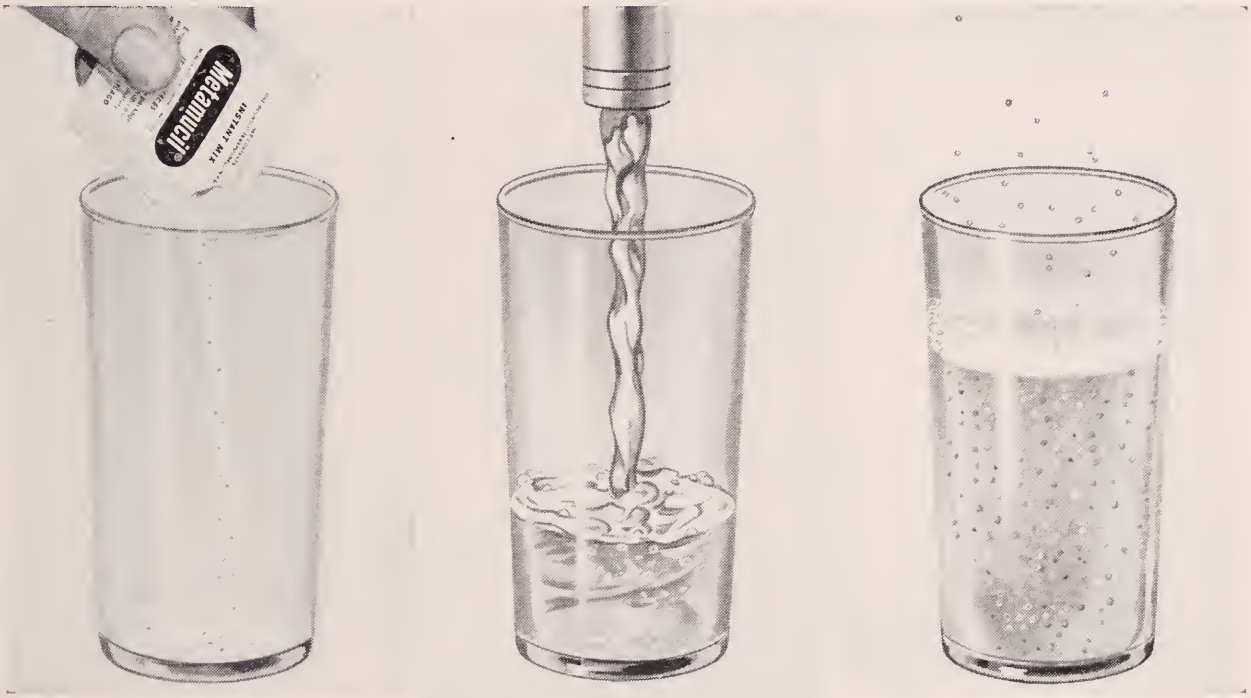

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When unaccustomed work produces
LOW BACK PAIN
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relaxes skeletal muscle spasm

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relieves
the pain
and disability
of
musculoskeletal
disorders

When enthusiastic gardening – or any of a host of other pleasant summer activities – brings on low back pain associated with skeletal muscle spasm, your patient need not be disabled or even uncomfortable for any length of time. The spasm can be relaxed with Trancopal, and relief of pain and disability follows promptly. The patient can usually continue his normal activities while taking Trancopal.

Lichtman[1,2] used Trancopal to treat patients with low back pain, stiff neck, bursitis, rheumatoid arthritis, osteoarthritis, trauma and postoperative muscle spasm. He noted that Trancopal brought satisfactory relief to 817 of 879 patients (excellent in 268, good in 448, fair in 101). "Chlormethazanone [Trancopal] not only relieved painful muscle spasm, but allowed the patients to resume their normal activities with no interference in performance of either manual or intellectual tasks."[1]

Gruenberg[3] also prescribed Trancopal for 70 patients with low back pain and observed that it brought marked improvement to all of them. "In addition to relieving spasm and pain, with subsequent improvement in movement and function, Trancopal reduced restlessness and irritability in a number of patients."[3] In another series of 193 patients Kearney[4] obtained relief with Trancopal in 181 patients suffering from low back pain and other forms of musculoskeletal spasm.

Trancopal enables the anxious patient to work or play. According to Gruenberg, "In addition to relieving muscle spasm in a variety of musculoskeletal and neurologic conditions, Trancopal also exerts a marked tranquilizing action in anxiety and tension states."[3] Lichtman[1] found that his patients in anxiety and tension states ". . . were in many instances able to continue their normal activities where previously they had been considerably restricted in their activities."[1] ". . . Trancopal is the most effective oral skeletal muscle relaxant and mild tranquilizer currently available." (Kearney)[4]

Side effects are rare and mild. "Trancopal is exceptionally safe for clinical use."[3] In the 70 patients with low back pain treated by Gruenberg,[3] the only side effect noted was a mild nausea which occurred in 2 patients. In Lichtman's group, "No patient discontinued chlormethazanone [Trancopal] because of intolerance."[1]

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effective tranquilizer

- In musculoskeletal disorders, effective in 91 per cent of patients.[5]
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  Blood pressure, pulse rate, respiration and digestive processes are unaffected by therapeutic dosage. It does not affect the hematopoietic system or liver and kidney function.
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Indications:

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Fibrositis
Myositis
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Anxiety and tension states
Asthma
Angina pectoris
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How Supplied: Trancopal Caplets®

200 mg. (green colored, scored), bottles of 100.

100 mg. (peach colored, scored), bottles of 100.

Dosage: Adults, 200 or 100 mg. orally three or four times daily. Relief of symptoms occurs in from fifteen to thirty minutes and lasts from four to six hours.

References: 1. Lichtman, A. L.: *Kentucky Acad. Gen. Pract. J.* 4:28, Oct., 1958 • 2. Lichtman, A. L.: Scientific Exhibit, Internat. Coll. Surgeons, Jan. 4-7, 1959, Miami Beach, Fla. • 3. Gruenberg, F.: *Current Therap. Res.* 2:1, Jan., 1960 • 4. Kearney, R. D.: *Current Therap. Res.* 2:127, April, 1960 • 5. Collective Study, Department of Medical Research, Winthrop Laboratories.

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For extra appetite appeal, your patient can team apples with dates. Raisins or bright fresh cranberries make a tasty surprise in a rough milled oatmeal muffin which, with other whole grains, offer cellulose plus Vitamin B Complex. Remember, plenty of liquid is important to make the cellulose bulky—about 8 to 10 glasses every day.

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INDICATIONS

HEAD: temporomandibular muscle spasm • NECK: acute torticollis, osteoarthritis of cervical spine with spasm of cervical muscles, whiplash injury • TRUNK AND CHEST: costochondritis, intercostal myositis, xiphodynia • BACK: acute and chronic lumbar strains and sprains, acute low back pain (unspecified), acute lumbar arthritis and traumatic injury, compression fracture, herniated intervertebral disc, post-disc syndrome, strained muscle(s) • EXTREMITIES: acute hip injury with muscle spasm, ankle sprain, arthritis (as of foot or knee), blow to shin followed by muscle spasm, bursitis, spasm or strain of muscle or muscle group, old fracture with recurrent spasm, Pellegrini-Stieda disease, tenosynovitis with associated pain and spasm.

-pain due to or associated with -spasm of skeletal muscle

a new muscle relaxant-analgesic

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ROBAXIN® WITH ASPIRIN

Many conditions, painful in themselves, often give rise to spasm of skeletal muscles. ROBAXISAL, the new dual-acting muscle relaxant-analgesic, treats both the pain and the spasm with marked success: In clinical studies on 311 patients, 12 investigators[1] reported satisfactory results in 86.5%. Each ROBAXISAL Tablet contains:

- A relaxant component — Robaxin* — widely recognized for its prompt, long-lasting relief of painful skeletal muscle spasm, with unusual freedom from undesired side effects . . . . . 400 mg.

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- An analgesic component—aspirin—whose pain-relieving effect is markedly enhanced by Robaxin, and which has added value as an anti-inflammatory and anti-rheumatic agent . . . . (5 gr.) 325 mg.

INDICATIONS: ROBAXISAL is indicated when analgesic as well as relaxant action is desired in the treatment of skeletal muscle spasm and severe concurrent pain. Typical conditions are disorders of the back, whiplash and other traumatic injuries, myositis, and pain and spasm associated with arthritis.

SUPPLY: ROBAXISAL Tablets (pink-and-white, laminated) in bottles of 100 and 500.

Also available: ROBAXIN Injectable, 1.0 Gm. in 10-cc. ampul. ROBAXIN Tablets, 0.5 Gm. (white, scored) in bottles of 50 and 500.

[1] Clinical reports in files of A. H. Robins Co., Inc., from: J. Allen, Madison, Wisc., B. Billow, New York, N. Y., B. Decker, Richmond, Va., C. Freeman, Jr., Augusta, Ga., R. B. Gordon, New York, N. Y., J. E. Holmblad, Schenectady, N. Y., L. Levy, New York, N. Y., N. LoBue, Chicago Heights, Ill., H. Nachman, Richmond, Va., A. Poindexter, Los Angeles, Cal., E. Rogers, Brooklyn, N. Y., K. H. Strong, Fairfield, Ia.

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STATE NEWS ITEMS

Dr. Sherman B. Forbes of Tampa and Drs. William J. Knauer Jr. and William J. Knauer Sr. of Jacksonville attended the clinical meeting of the Wilmer Residents Association held in April at the Wilmer Ophthalmological Institute of the Johns Hopkins Hospital and University in Baltimore.

Physicians from the greater Miami area serving as chairmen of the various committees for the 109th annual meeting of the American Medical Association at Miami Beach June 13-17 include Drs. Reuben B. Chrisman Jr. and Homer L. Pearson Jr., General Chairmen; Drs. Franklin J. Evans and Robert P. Keiser, Associate Chairmen; Dr. Edward W. Cullipher, House of Delegates Dinner; Dr. Harold Rand, Hotels; Dr. Ralph W. Jack, President's Reception; Dr. L. Washington Dowlen, Publicity; Dr. John D. Milton, Clubs and Alumni; Dr. C. Howard McDevitt Jr., Entertainment and Hospitality; Dr. Ralph S. Sappenfield, Finance; Dr. Charles R. Burbacher, Golf; Dr. Nelson Zivitz, Registration; Dr. Richard M. Fleming, Television; Dr. Milton S. Goldman, Transportation; Dr. W. Tracy Haverfield, Fishing; Dr. Leonard L. Weil, Medical Aid, and Dr. Jean J. Perdue, Woman Doctors. A total of 132 physicians, mostly from the Miami area, will be serving on the committees in various capacities.

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The Second Annual Florida Medical Forum sponsored by the Lee-Charlotte-Hendry Medical Society and the Lee County Chamber of Commerce was held April 4-5 in Exhibition Hall at Fort Myers. Guest speakers included Dr. Lester R. Dragstedt of Gainesville, Professor of Surgery at the College of Medicine, University of Florida; Dr. Philip S. Hench of Rochester, Minn., Senior Consultant and Head, Section on Rheumatic Diseases, Mayo Clinic; Dr. Robert S. Glen of Gainesville, Assistant Professor, Department of Psychiatry, College of Medicine, University of Florida, and Dr. Gilbert H. Marquardt of Chicago, Chief of Consulting Staff, Oak Forest Hospital for Chronic Diseases. The speakers were introduced by Dr. Wilson D. Rumberger, past president of the Lee-Hendry County Medical Society. Dr. George D. Hopkins II, president of the Society, and Mr. Ellis G. Galleher Jr., of the Chamber of Commerce, were in charge of arrangements.

Dr. John S. Neill of Tampa, Assistant Health Officer of Hillsborough County, has been elected chairman of the State Association of County Health Officers. Dr. Neill D. Miller of Fort Pierce, Health Officer of St. Lucie, Martin and

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Louis S. Goldstein Clinical Medicine 59:455 (1952) / Kass Archives of Internal Medicine Vol. 100, p. 709.

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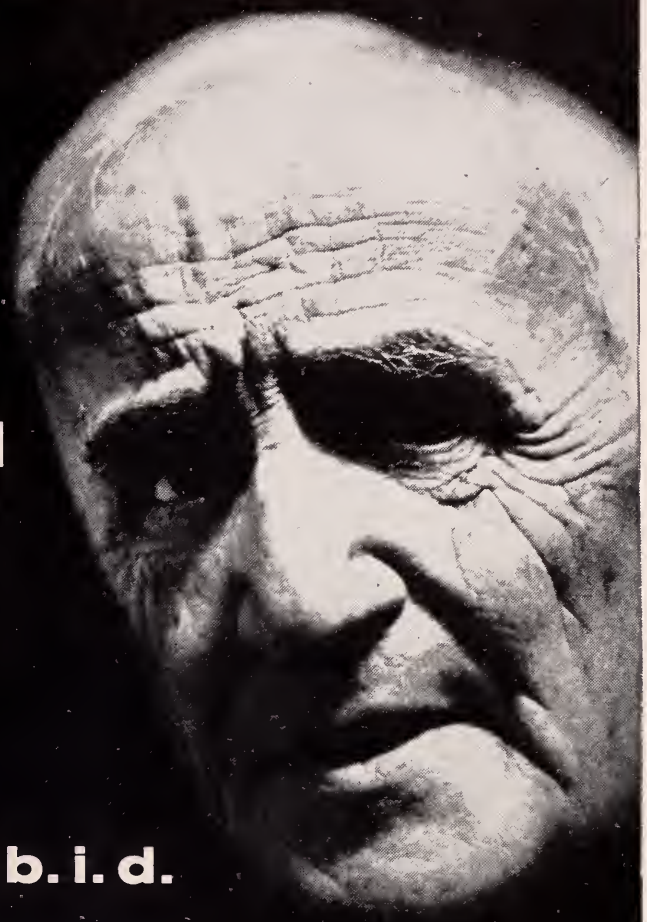

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- Supplied: Bottles of 42 Tablets (3 weeks' treatment)

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Okeechobee Counties, has been chosen as vice chairman, and Dr. Edward G. Byrne of Gainesville, Health Officer of Alachua County, secretary-treasurer.

The 44th Annual Tournament of the American Medical Golf Association is being held Monday, June 13, at the Diplomat Hotel and Country Club in Hollywood. Tee off has been scheduled for 8:00 a.m. through 2:00 p.m.

The luncheon of Northwestern University Medical Alumni has been scheduled for 12:15 p.m. June 14 in the Imperial Room of the Roney Plaza Hotel, Miami, according to announcement by Dr. Herbert W. Virgin Jr. of Miami, chairman of the Northwestern University Luncheon Committee. Dr. Richard Young, Dean of the Medical School, will be principal speaker.

Dr. Walter W. Sackett Jr. of Miami has been elected to the Board of Directors of the American Academy of General Practice.

The Second Annual Pre-Convention School Health Meeting, jointly sponsored by the American Medical Association and the American School Health Association, will be held Sunday evening, June 12, in the Medallion Room of the Carillon Hotel, Miami Beach, immediately prior to the annual meeting of the American Medical Association. A panel of outstanding authorities will present a symposium on various phases of school health. A discussion period will follow.

The 57 members of the fifth graduating class of the University of Miami School of Medicine will intern in 22 different hospitals, in 11 states, according to Dr. Homer F. Marsh, Dean. Hospitals in Miami, Orlando, Jacksonville, Palm Beach, Tampa and St. Petersburg will have 24 of the graduates.

The annual meeting of the Southern Trudeau Society and also the Southern Tuberculosis Conference will be held September 14-16 at the Hotel Francis Marion, Charleston, S. C.

Application forms for space in the Scientific Exhibit at the Washington, D. C., Clinical Meetting of the American Medical Association, November 28 to December 1, are now available.

(Continued on page 1586)

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Vitamin B-2	2 mg.
Vitamin B-6	0.8 mg.
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Vitamin K (Menadione)	0.25 mg.
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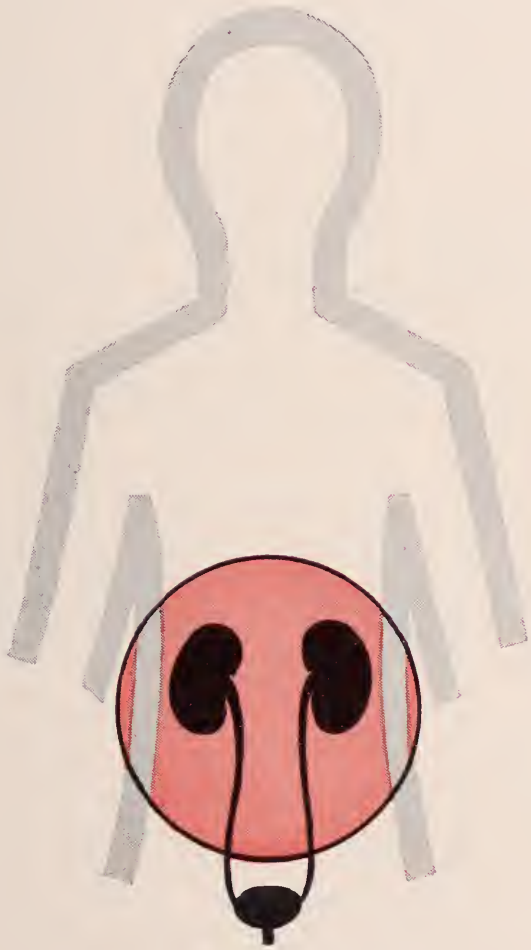

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now...there is a way to prompt, dependable relief of back distress

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POTENT — rapid relief in acute conditions

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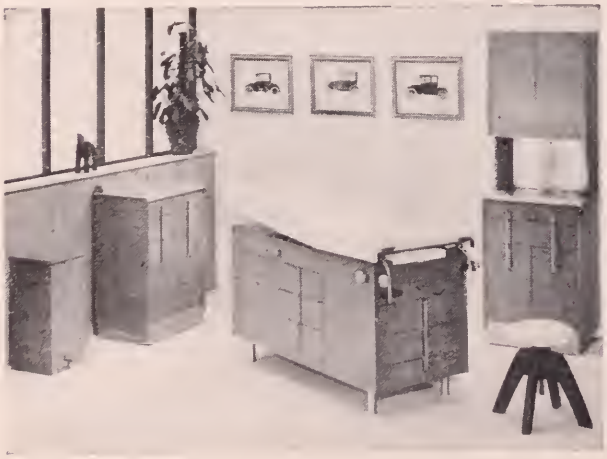

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meprobamate 400 mg., with d-amphetamine sulfate 5 mg., Tablets

FOR THERAPY
OF OVERWEIGHT PATIENTS

- d-amphetamine depresses appetite and elevates mood
- meprobamate eases tensions of dieting (yet without overstimulation, insomnia or barbiturate hangover).

Dosage: One tablet one-half to one hour before each meal.

A LOGICAL COMBINATION
IN
APPETITE CONTROL

Lederle

(Continued from page 1580)

They may be procured by writing directly to Dr. Charles H. Bramlitt, Director, Department of Scientific Assembly, American Medical Association, 535 N. Dearborn St., Chicago 10. Applications close on August 1.

Dr. Floyd K. Hurt of Jacksonville, president of the Duval County Medical Society, was principal speaker at the dedication of the new wing of the Jacksonville Blood Bank held the last of April.

Dr. James T. Cook Jr. of Marianna has been elected state chairman of the Florida Medical Committee for Better Government.

Dr. Walter C. Jones of Miami has been chosen president-elect of the Southeastern Surgical Congress.

Dr. Leo M. Wachtel of Jacksonville, President of the Florida Medical Association, extended official greetings from the Association to the Convention of The Florida Bar held in Miami May 5-7.

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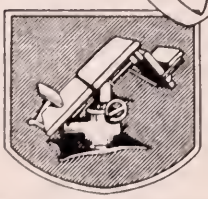

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Prompt and more dependable control of virtually all diarrheas can be achieved with the comprehensive DONNAGEL formula, which provides adsorbent, demulcent, antispasmodic and sedative effects—with or without an antibiotic. Early re-establishment of normal bowel function is assured—for all ages, in all seasons.

DONNAGEL: In each 30 cc. (1 fl. oz.):

Kaolin (90 gr.)	6.0 Gm.
Pectin (2 gr.)	142.8 mg.
Hyoscyamine sulfate	0.1037 mg.
Atropine sulfate	0.0194 mg.
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Same formula, plus

Neomycin sulfate	300 mg.

(Equal to neomycin base, 210 mg.)

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Recent JAMA editorial statement clarifies the current controversy about dietary fats

Excerpted from the March 12, 1960, issue of The Journal of The American Medical Association:

"It is accepted generally that specific alteration in the diet will lower the concentration of cholesterol in the blood. The most effective results to date have been achieved by increasing consumption of polyunsaturated fatty acids, particularly linoleic acid. However, indefinitive and conflicting information has left much to the imagination of some food processors. Some of the largest vegetable oil processors in the United States have implied in advertisements that the cholesterol level can be lowered merely by adding polyunsaturated fatty acids to the diet. This selling campaign has created confusion among lay people, making it increasingly important that the physician clarify for his patients the conditions under which changes in the diet will be effective.

The patient should understand that if he increases his consumption of polyunsaturated fatty acids without reducing his intake of other fats, little is gained save for additional calories which could lead to obesity. A particular regimen will be effective only if polyunsaturated fatty acids are responsible for an appreciable percentage of the total fat calories. That is, they must replace rather than supplement some of the saturated fats and oils already in the diet.

* * *

Some manufacturers cite the "iodine number" of a fat or oil as evidence of the unsaturated fatty acid content of their product. This number is not a reliable indicator of therapeutic value because it measures monounsaturated and polyunsaturated fatty-acid content at the same time. A monounsaturated acid, like oleic, takes up two iodine atoms but does not affect the cholesterol concentration of the blood. A polyunsaturated acid, like linoleic, takes up four iodine atoms. In a product containing large amounts of oleic acid and small amounts of linoleic acid, the iodine number is nearly the same as it would be for a product containing little oleic acid and a modest amount of linoleic acid. Cottonseed oil has an iodine number of 110 and corn oil a number of 127; yet they each have about the same amount of linoleic acid.

* * *

Low-fat diets will not reduce the concentration of circulating cholesterol and lipoproteins as effectively as will diets containing an adequate percentage of polyunsaturated fatty acids. Weight-reduction regimens are basically low in fat, and if a lowered cholesterol level is necessary, planning must be done to maintain the proper ratio of saturated to unsaturated fats."

* * *

Herbert Pollack, M.D.
Associate Professor of Clinical Medicine
Postgraduate Medical School
New York University, New York

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Wesson is 100% cottonseed oil–winterized and of selected quality

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Oleic acid glycerides (mono-unsaturated)	16-20%
Total unsaturated	70-75%
Palmitic, stearic and myristic glycerides (saturated)	25-30%
Phytosterol (predominantly beta sitosterol)	0.3-0.5%
Total tocopherols	0.09-0.12%

Never hydrogenated—completely salt free

Each pint of Wesson contains 437-524 Int. Units of Vitamin E

FREE Wesson recipes, available in quantity for your patients, show how to prepare meats, seafoods, vegetables, salads and desserts with poly-unsaturated vegetable oil. Request quantity needed from The Wesson People, Dept. N, 210 Baronne St., New Orleans 12, La.

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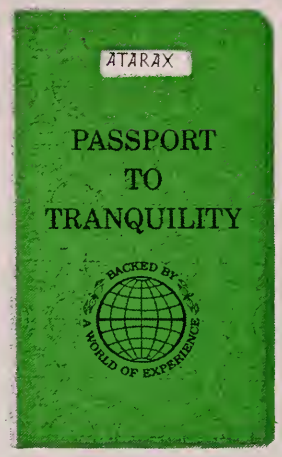

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Widest latitude of safety and flexibility—no serious adverse clinical reaction ever documented.
Chemically distinct among tranquilizers—not a phenothiazine or a meprobamate.
Added frontiers of usefulness—antihistaminic; mildly antiarrhythmic; does not stimulate gastric secretion.

Special Advantages	Supportive Clinical Observation	...and for additional evidence
IN CHILDREN unusually safe; tasty syrup, 10 mg. tablet	"...Atarax appeared to reduce anxiety and restlessness, improve sleep patterns and make the child more amenable to the development of new patterns of behavior...." Freedman, A. M.: Pediat. Clin. North America **5**:573 (Aug.) 1958.	Bayart, J.: Acta paediat. belg. **10**:164, 1956. Ayd, F. J., Jr.: California Med. **87**:75 (Aug.) 1957. Nathan, L. A., and Andelman, M. B.: Illinois M. J. **112**:171 (Oct.) 1957.
IN ELDERLY PATIENTS well tolerated by debilitated patients	"...seems to be the agent of choice in patients suffering from removal disorientation, confusion, conversion hysteria and other psychoneurotic conditions occurring in old age." Smigel, J. O., et al.: J. Am. Geriatrics Soc. **7**:61 (Jan.) 1959.	Settel, E.: Am. Pract. & Digest Treat. **8**:1584 (Oct.) 1957. Negri, F.: Minerva med. **48**:607 (Feb. 21) 1957. Shalowitz, M.: Geriatrics **11**:312 (July) 1956.
IN ALLERGIC PATIENTS useful adjunctive therapy for asthma and dermatosis; particularly effective in urticaria	"All [asthmatic] patients reported greater calmness and were able to rest and sleep better...and led a more normal life....In chronic and acute urticaria, however, hydroxyzine was effective as the sole medicament." Santos, I. M., and Unger, L.: Presented at 14th Annual Congress, American College of Allergists, Atlantic City, New Jersey, April 23-25, 1958.	Eisenberg, B. C.: J.A.M.A. **169**:14 (Jan. 3) 1959. Coirault, R., et al.: Presse méd. **64**:2239 (Dec. 26) 1956. Robinson, H. M., Jr., et al.: South. M. J. **50**:1282 (Oct.) 1957.
IN HYPEREMOTIVE ADULTS does not impair mental acuity	"...especially well-suited for ambulatory neurotics who must work, drive a car, or operate machinery." Ayd, F. J., Jr.: New York J. Med. **57**:1742 (May 15) 1957.	Garber, R. C., Jr.: J. Florida M. A. **45**:549 (Nov.) 1958. Menger, H. C.: New York J. Med. **58**:1684 (May 15) 1958. Farah, L.: Internat. Rec. Med. **169**:379 (June) 1956.

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usual medications act only here

NEW **isoclor** acts here to relieve both nasal and chest discomfort

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provides both . . . upper respiratory decongestion and bronchial decongestion

Many hay fever patients also experience chest discomfort. For these patients, new ISOCLOR provides relief along the entire respiratory tract.

COMBINES the nasal and bronchial decongestant action of d-isoephedrine with the histamine blocking action of chlorpheniramine.

RELIEVES the discomforts of rhinorrhea, itching, sneezing, hyperlacrimation and post nasal drip—let s the patient get a full night's rest—with minimal daytime drowsiness, CNS or pressor stimulation.

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d-Isoephedrine HCl	25 mg.	12.5 mg.

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Tablets: 125 mg. and 250 mg., bottles of 25 and 100. Powder for Oral Solution (lemon-lime flavored), 1.5 Gm. bottle (125 mg. per 5 cc. teaspoonful).

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Employs the N[1] acetyl form of KYNEX to impart high palatability yet retain single-daily-dose effectiveness and rapid, high sustained action against sulfa-susceptible infections. **Dosage:** first day, 1 tsp. (250 mg) for each 20 lbs.; thereafter, ½ tsp. daily for each 20 lbs. For 80 lbs., use adult dosage of 4 tsp. (1.0 Gm.) initially; and 2 tsp. (0.5 Gm.) thereafter. Taken once a day—preferably after a meal. **Supplied:** Each tsp. (5 cc.) contains 250 mg. sulfamethoxypyridazine activity. Bottles of 4 and 16 fl. oz.

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FOR LUPUS ERYTHEMATOSUS AND LIGHT-SENSITIVITY ERUPTIONS

WHAT IT IS:
A combination of Atabrine® hydrochloride 25 mg., Aralen® phosphate 65 mg. and Plaquenil® sulfate 50 mg.

WHAT IT'S FOR:
Treatment of lupus erythematosus (chronic discoid type) and polymorphic light eruptions (light-sensitivity eruptions, solar urticaria or dermatitis).

HOW IT ACTS:
Each of the three components produces beneficial response in lupus erythematosus and light-sensitivity eruptions. Since the dose of each of the Triquin components is very low, overall toxicity is reduced and clinical tolerance improved. Furthermore, the three components appear to act synergistically.

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Triquin tablets in bottles of 100, sold on prescription only.

Write for TRIQUIN booklet.

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A logical combination for appetite suppression

meprobamate **plus** d-amphetamine...suppresses appetite...elevates mood... reduces tension...**without** insomnia, overstimulation or barbiturate hangover.

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Dosage: One tablet one-half to one hour before each meal.

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1. Lippmann, O.: Arch. Ophth. **57**:339, March 1957
2. Gordon, D.M.: Am. J. Ophth. **46**:740, November 1958.

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*Adams, L. D.: The Commonsense Book of Wine, New York, David McKay Company, Inc., 1958, pp. 162-163.

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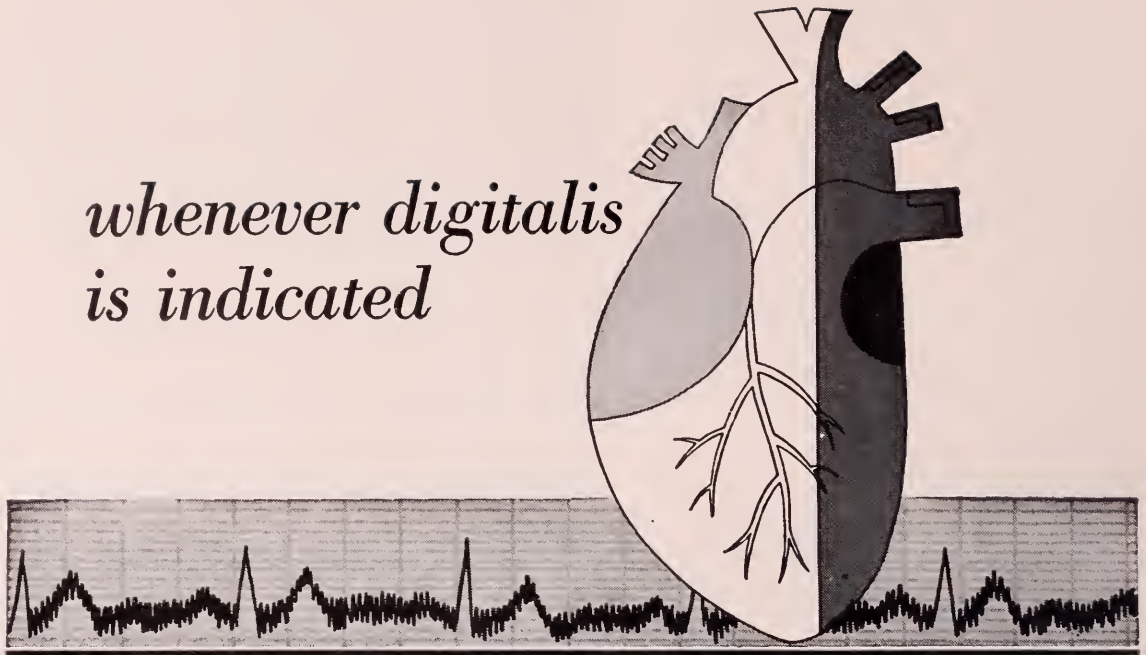

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Lown, B., and Levine, S. A.: Current Concepts in Digitalis Therapy, Boston, Little, Brown & Company, 1954, p. 23, par. 2.

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Because the active ingredients of a spermicidal preparation must diffuse rapidly into the seminal clot and throughout the vaginal canal to be clinically effective. Lanesta Gel offers this *dual* protection. Its four spermicidal agents quickly invade the clot to stop the main body of sperm. It spreads evenly and quickly throughout the vaginal canal—seeks out every wrinkle and fold that may offer concealment to sperm. With this rapid diffusion, your patient receives full benefit of the swift spermicidal action of Lanesta Gel — in minutes — a decisive measure in conception control.

In Lanesta Gel *7-chloro-4-indanol,* a new, effective, nonirritating, nonallergenic spermicide, produces immediate immobilization of spermatozoa in dilution of up to 1:4,000. The addition of 10 per cent NaCl in ionic form greatly accelerates spermicidal action. Ricinoleic acid facilitates rapid inactivation and immobilization of spermatozoa and sodium lauryl sulfate acts as a dispersing agent and spermicidal detergent.

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a well balanced therapy in all forms of rheumatic disorder

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Sterazolidin®, brand of prednisone-phenylbutazone: Each capsule contains prednisone, 1.25 mg.; Butazolidin® (brand of phenylbutazone), 50 mg.; dried aluminum hydroxide gel, 100 mg.; magnesium trisilicate, 150 mg.; homatropine methylbromide, 1.25 mg. Bottles of 100.

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(Continued on page 1614)

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- Curbs excessive peristalsis
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- Soothes inflamed mucosa
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EFFECTIVE ANTIDIARRHEAL

FORMULA: *Each 15 cc. (tablespoon) contains:*

Sulfaguanidine	2 Gm.
Pectin	225 mg.
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Opium tincture	0.08 cc.
(equivalent to 2 cc. paregoric)	

DOSAGE: **Adults:** Initially 1 or 2 tablespoons from four to six times daily, or 1 or 2 teaspoons after each loose bowel movement; reduce dosage as diarrhea subsides.

Children: ½ teaspoon (=2.5 cc.) per 15 lb. of body weight every four hours day and night until stools are reduced to five daily, then every eight hours for three days.

SUPPLIED: *Bottles of 16 fl. oz. (raspberry flavor, pink color)*
Exempt Narcotic. Available on Prescription Only.

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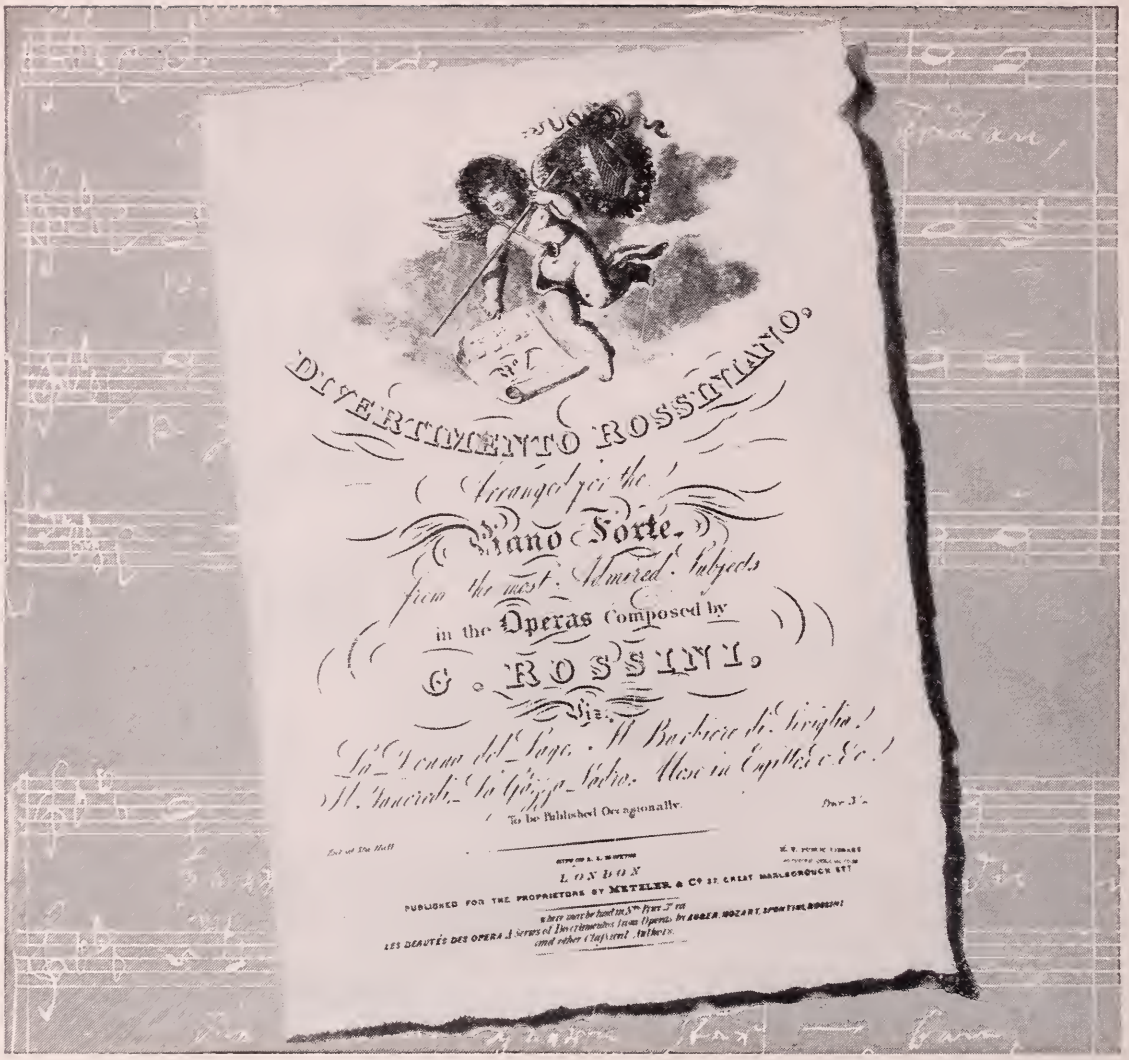

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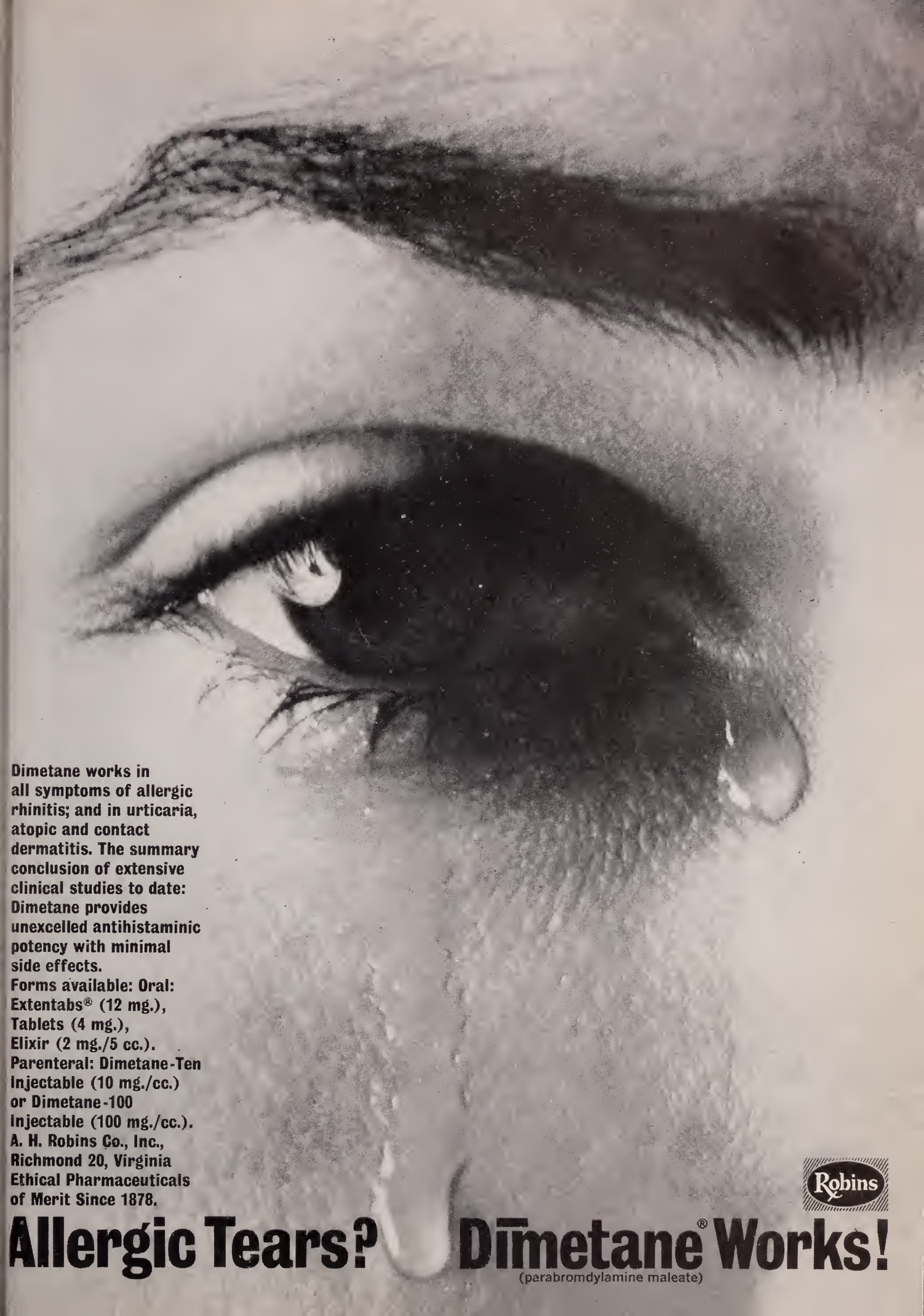
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...relief from pollen allergies

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Each Triaminic timed-release Tablet provides:

Phenylpropanolamine HCl	50 mg.
Pheniramine maleate	25 mg.
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also available:

TRIAMINIC JUVELETS® ½ the formulation of the Triaminic Tablet with timed-release action.

TRIAMINIC SYRUP each teaspoonful (5 ml.) provides ¼ the formulation of the Triaminic Tablet.

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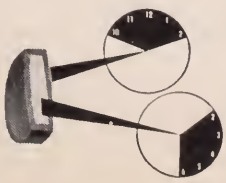

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Florida Medical Association Woman's Auxiliary To Sponsor Luncheon

The Woman's Auxiliary to the Florida Medical Association will sponsor the "Florida Fantasy Luncheon" Tuesday, May 14, in the Deauville Hotel on Miami Beach during the annual meeting of the American Medical Association. Scheduled to begin at 12:30 p.m., the luncheon is open to physicians and their wives. The price is $4.00. Dr. Louis M. Orr of Orlando, President of the American Medical Association, will be the guest speaker.

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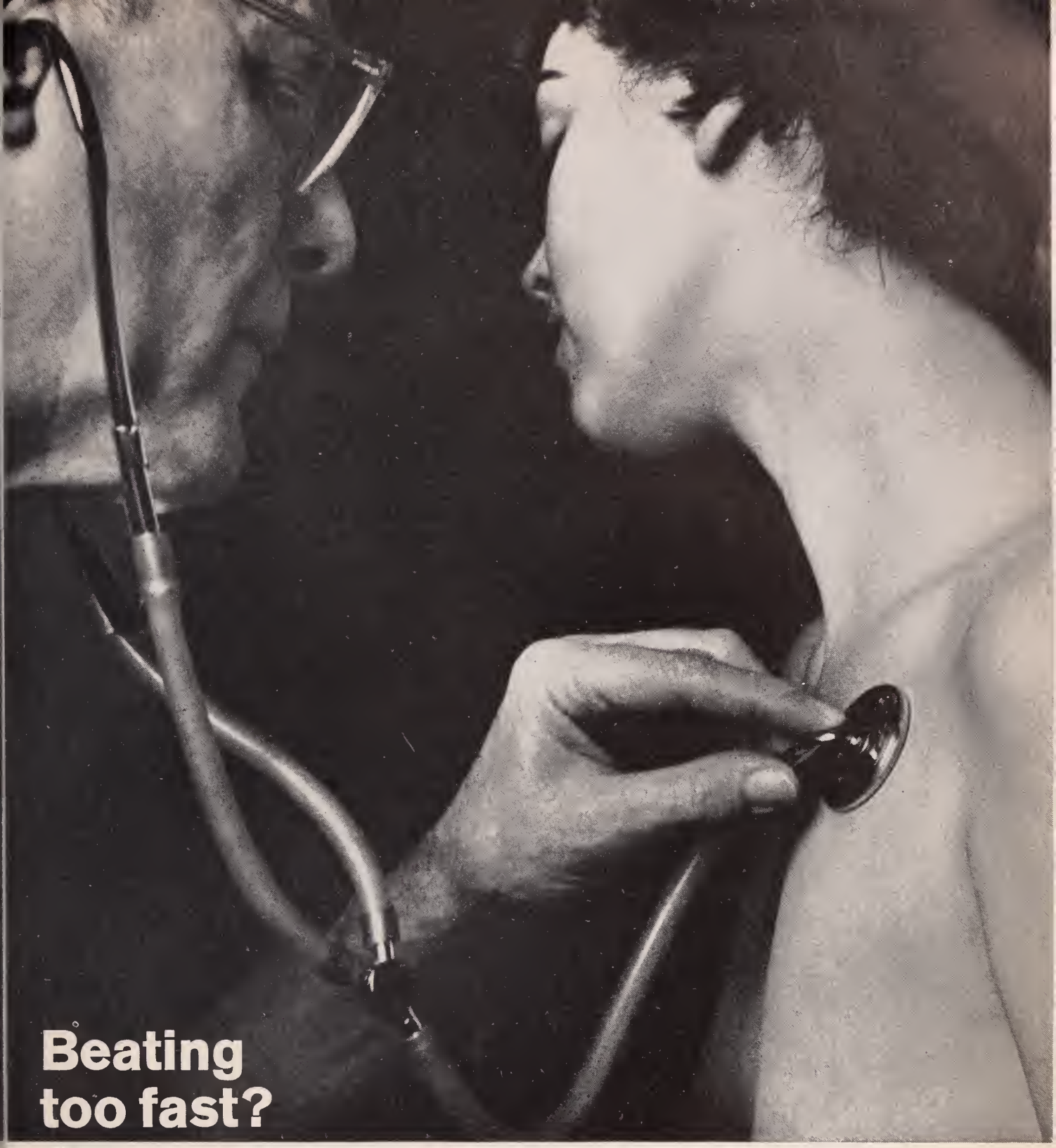

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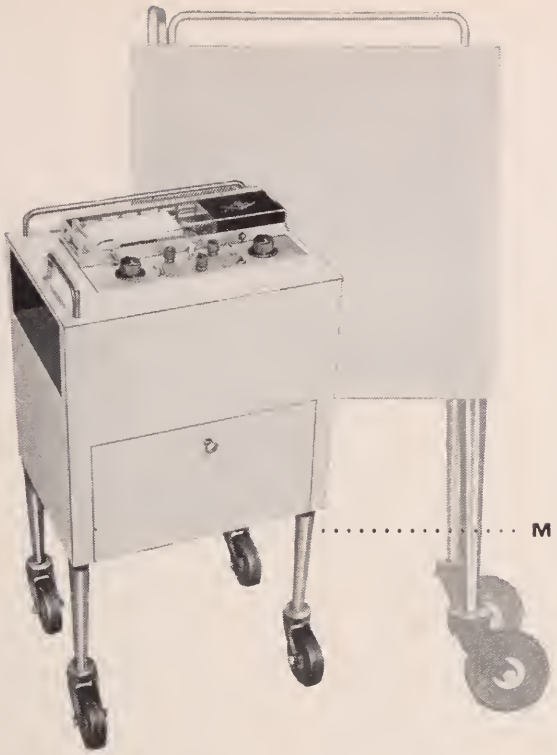

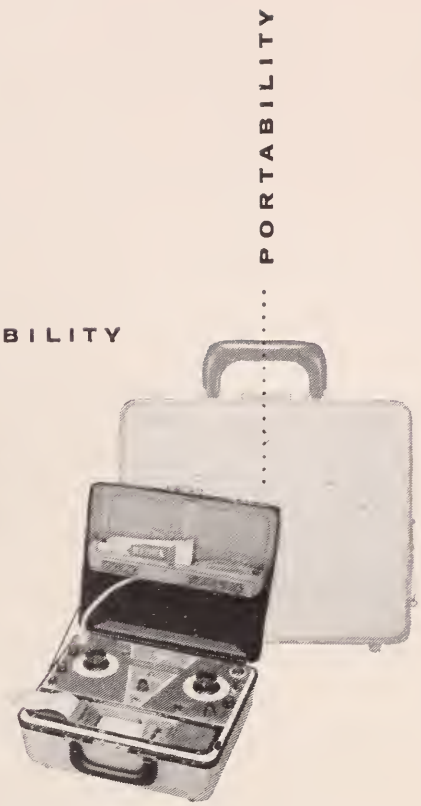

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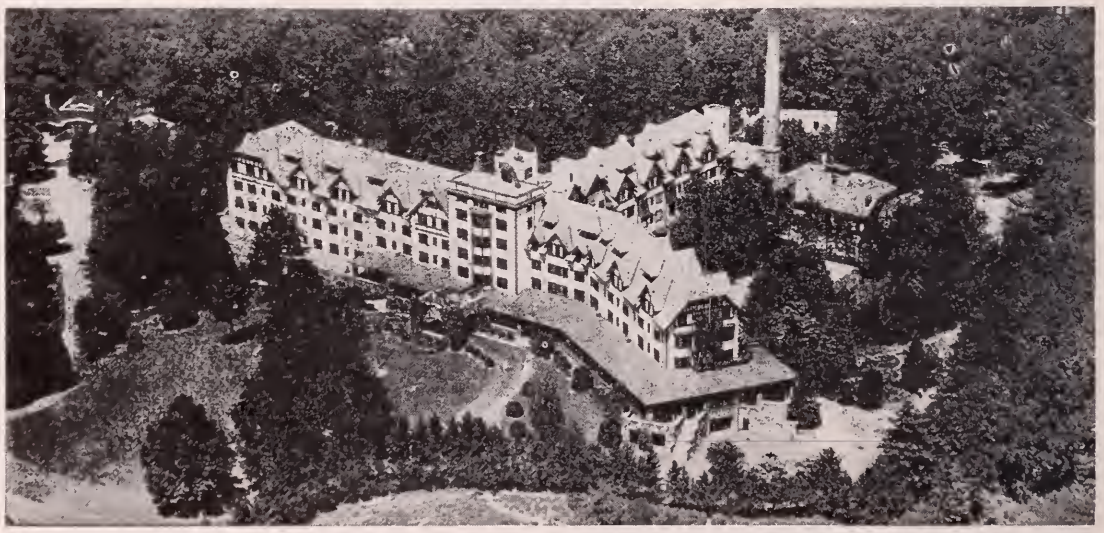

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Alachua	Eugene H. Cummings, Gainesville	Richard E. Perry, Gainesville	2nd Tues.		78
* *Bradford, Gilchrist, Union*					
Bay	Donald H. Anderson, Panama City	John L. Fishel, Panama City	2nd Tues.		33
Brevard	Cyrus E. Warden, Melbourne	Spencer C. Manrodt, Melbourne	1st Tues.	2	69
Broward	Anthony C. Galluccio, Hollywood	Frederick W. Fisher, Ft. Lauderdale	4th Tues.	30	265
Charlotte	Robert H. Shedd, Punta Gorda	Carl N. Reilly, Punta Gorda	2nd Tues.		6
Collier	Loral F. Gwaltney, Naples	Ethel H. Trygstad, Naples	4th Tues.		14
Columbia	Harry S. Howell, Lake City	Thomas H. Bates, Lake City	3rd Wed.		12
* *Baker*					
Dade	Franklin J. Evans, Coral Gables	DeWitt C. Daughtry, Miami	1st Tues.	74	1008
DeSoto-Hardee-Glades	Harold S. Agnew, Arcadia	Elmer J. Schmierer, Arcadia	1st Tues.		13
Duval	Floyd K. Hurt, Jacksonville	Albert D. Rood, Jacksonville	1st Tues.	5	363
* *Clay*					
Escambia	William J. Overman, Warrington	Howard E. Herring Jr., Pensacola	2nd Tues.	1	119
Franklin-Gulf	Photis J. Nichols, Apalachicola	Joseph P. Hendrix, Port St. Joe	Last Wed.		7
Highlands	Hubert W. Coleman, Avon Park	Samuel A. King, Avon Park	3rd Mon.	1	13
Hillsborough	Linus W. Hewit, Tampa	Frank A. Massari, Tampa	1st Tues.	2	252
Indian River	Charles F. Rattray Jr., Vero Beach	Walter W. McCorkle, Vero Beach	2nd Tues.	2	14
Jackson-Calhoun	William R. Wandeck, Marianna	Francis M. Watson, Marianna	Quarterly		17
Lake	Arthur P. Buchanan, Leesburg	Thomas D. Weaver, Clermont	1st Wed.	3	36
* *Sumter*					
Lee-Hendry	George D. Hopkins II, Ft. Myers	Leland K. Glenn, Ft. Myers	3rd Mon.		38
Leon-Gadsden-Liberty-Wakulla-Jefferson	Edson J. Andrews, Tallahassee	David J. McCulloch, Tallahassee	1st Mon.	8	75
Madison	Julian M. Durant, Madison	Thomas G. Bouland Jr., Madison	1st Tues.	1	6
Manatee	Willett E. Wentzel, Bradenton	John A. Shively, Bradenton	2nd Tues.		40
Marion	Robert E. Thompson, Ocala	William C. Butscher, Ocala	3rd Tues.	1	33
* *Levy*					
Monroe	Walter R. McCook, Key West	Joseph L. G. Lester Jr., Key West	1st Thurs.		15
Nassau	David D. Bennett Jr., Callahan	Cecil B. Brewton, Fernandina Beach	1st Thurs.	2	10
Orange	W. Dean Steward, Orlando	Robert W. Curry, Orlando	3rd Wed.	24	229
* *Osceola*					
Palm Beach	Willard F. Ande, W. Palm Beach	Herman Baxt, W. Palm Beach	4th Mon.	22	187
Pasco-Hernando-Citrus	William H. Walters Jr., Lacoochee	W. Wardlaw Jones, Dade City	2nd Thurs.	1	21
Pinellas	Chas. L. Farrington, St. Petersburg	Whitman C. McConnell, St. Petersburg	1st Mon.	13	311
Polk	Charles Larsen Jr.,Lakeland	Clarence L. Anderson, Lakeland	2nd Wed.	13	133
Putnam	Roy E. Campbell, Palatka	Norman B. Edgerton, Palatka	2nd Tues.		15
St. Johns	S. Raymond Cafaro, St. Augustine	Joseph A. Shelley, St. Augustine	3rd Tues.		19
St. Lucie-Okeechobee-Martin	Joseph H. Batsche, Fort Pierce	Maltby F. Watkins, Ft. Pierce	3rd Thurs.		29
Sarasota	James E. Kicklighter, Sarasota	Thomas G. Dickinson, Sarasota	2nd Tues.	3	91
Seminole	Edwin Epstein, Sanford	Robert J. Smith, Sanford	2nd Tues.	1	18
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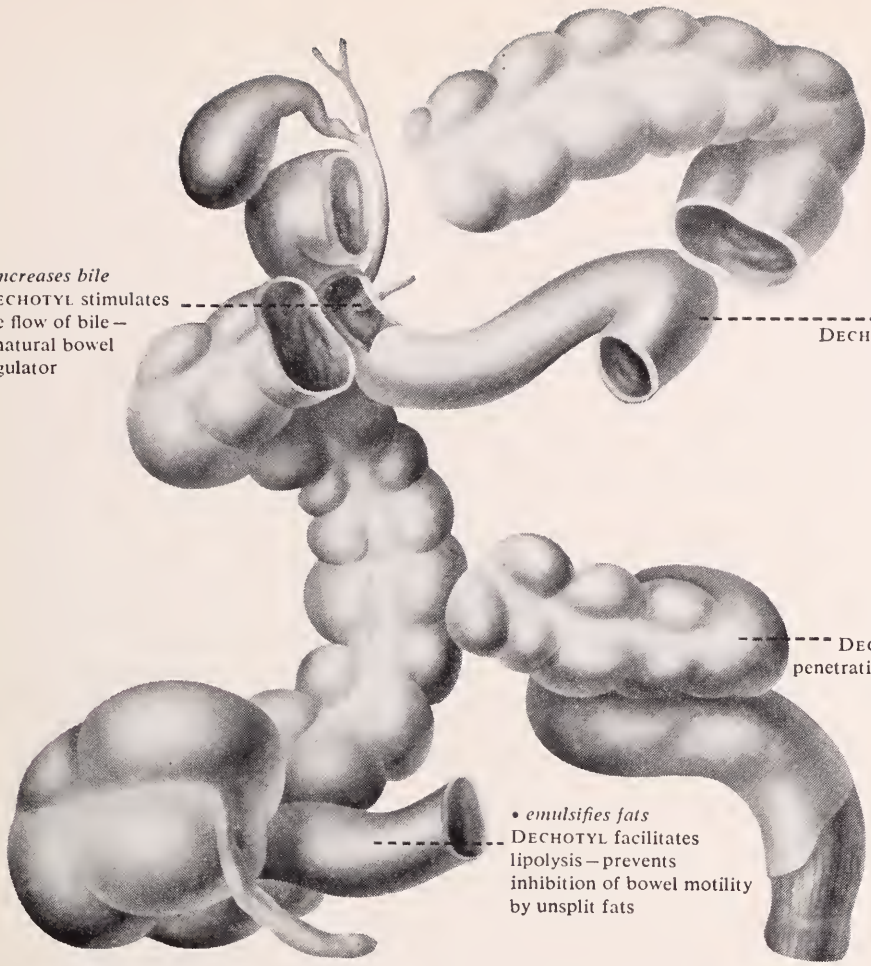
* *Dixie*					
Volusia	Jas. J. Cunningham, New Smyrna Bch.	John J. Cheleden, Daytona Beach	2nd Tues.	3	104
* *Flagler*					
Walton-Okaloosa-Santa Rosa	Joseph C. Wilson, Ft. Walton Beach	Wm. W. Thompson, Ft. Walton Beach	3rd Tues.	4	33
Washington-Holmes	Walter H. Shehee, Chipley	L. H. Paul, Bonifay	Quarterly	1	4
				217	3,745
			Grand Total	3,962	



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